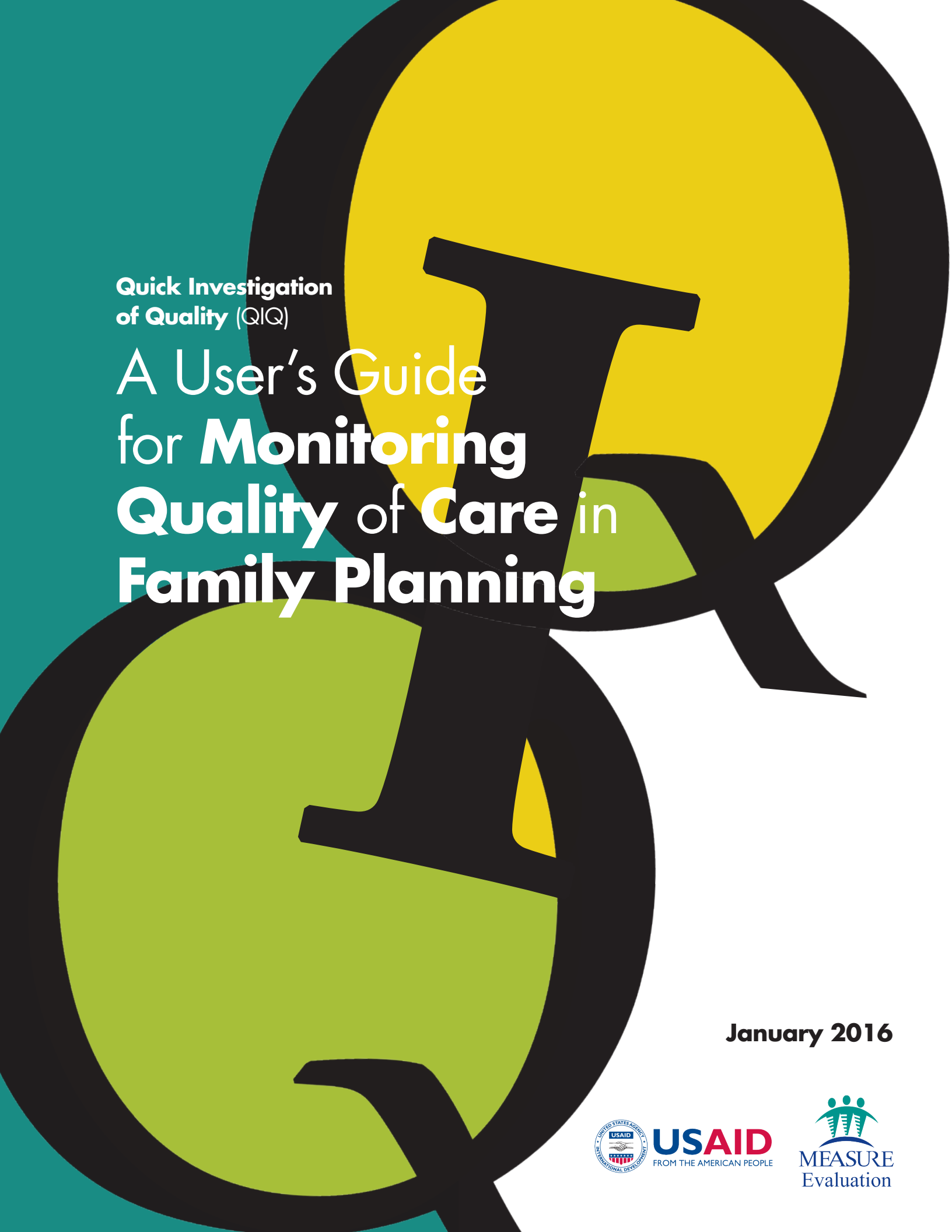
Quick Investigation of Quality (QIQ)

A User's Guide for **Monitoring Quality** of **Care** in **Family Planning**



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MEASURE Evaluation

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LIST OF ACRONYMS

CA	Cooperating Agency
CPI	Client-Provider Interaction
CQI	Continuous Quality Improvement
FP	Family Planning
GATHER	Greet clients, Ask clients about themselves, Tell clients about FP methods, Help clients choose a method, Explain how to use method chosen, Refer or return for follow-up
IEC	Information, Education and Communication
LAM	Lactation Amenorrhoea Method
M&E	Monitoring and Evaluation
MAQ	Maximizing Access and Quality
MCH	Maternal and Child Health
MOH	Ministry of Health
QoC	Quality of Care
QIQ	Quick Investigation of Quality
RH	Reproductive Health
SDP	Service Delivery Point
TQM	Total Quality Management

FOREWORD

The Quick Investigation of Quality (QIQ) A User's Guide for Monitoring Quality of Care in Family Planning was first published in 2001. Since this time, much has happened in the field of family planning, including the push to better integrate family planning with other health services. Yet despite the passage of almost a decade and a half, a review of the guide revealed that its tools and guidance on the measurement of quality are still appropriate for current programming needs. Client's rights to quality services remains in the forefront of global family planning initiatives. Tools such as the QIQ help ensure that services are upholding and maintaining appropriate standards of quality to support these rights.

The purpose of the second edition is to provide users with an updated version of the QIQ guide in order to support its continued use as a resource for monitoring service quality. The updated guide contains all the original elements, though a few technical changes to the document were required. For example, to reflect the fact that family planning services are working to include men as clients, the guidance and tools are now gender-inclusive. Additionally, lists of contraceptives were updated to reflect current language and the latest contraceptive technologies. These lists correspond to the method lists used by the updated Service Provision Assessments (SPAs) whenever possible.

The updated QIQ guide is intended to be easier to navigate. Sections are now color-referenced and hyperlinks allow for quick access to sections of interest. While the document maintains its original length and comprehensiveness, it should be easier to identify and move to the chapters and tools of most interest.

Full assessments of service quality should include all 25 indicators and three data collection methods, however, users are invited to pull out, revise, and in other ways adapt the tools as needed to fit their particular monitoring needs. We also remind users that the tools can be modified for use with other areas of health as well. With these considerations, we hope the updated guide continues to meet the service quality monitoring needs of family planning and reproductive health programs, whether they are national, sub-national, public, or private.

PREFACE

This user's guide contains materials needed to design and implement the Quick Investigation of Quality (QIQ) in a given country. QIQ refers to the set of three related data collection instruments designed to monitor 25 indicators of quality of care in clinic-based family planning programs. This volume includes an overview of the QIQ (including objectives, short list of indicators, and methodological and ethical issues), guidelines for sampling and training of field personnel, instruments and guidelines for data collection, and summary results from short list of indicators (tabular and graphic forms). Originally developed with funding from the USAID Office of Population, this methodology continues to provide a low-cost, practical means to routinely monitor quality of care in family planning and other reproductive health services. It can be used by governments, USAID Missions, and other organizations and programs interested in tracking quality. The MEASURE *Evaluation* Project worked in collaboration with members of the Monitoring and Evaluation Subcommittee of the Maximizing Access and Quality (MAQ) initiative[1] and assumed the lead role in developing and testing the methodology in five countries – Ecuador, Morocco, Turkey, Uganda, and Zimbabwe. The methodology has since been used to assess quality of services in many additional countries, such as Indonesia (2002), Madagascar (2005), Sri Lanka (2008), and Nigeria (2010) and continues to serve as a resource for research on quality of care (Kagurusi, 2013; Tumlinson, Speizer, Curtis and Pence, 2014).

The following are the three avenues through which the methodology and the results of the original field tests of the Quick Investigation of Quality (QIQ) are available:

- **Quick Investigation of Quality (QIQ): A User's Guide for Monitoring Quality of Care in Family Planning**

  The user's guide contains all of the tools necessary to routinely monitor quality of care from data collection to data analysis and presentation of results. It contains the following:

  - overview of the QIQ (including objectives, short list of indicators, and methodological and ethical issues);
  - sampling guidelines;
  - guidelines for training field personnel;
  - instruments and guidelines for data collection;
  - summary results from short list of indicators (tabular and graphic).

- **Monitoring Quality of Care in Family Planning by the Quick Investigation of Quality (QIQ): Country Reports**

  This compilation includes the results from the field test in four countries, as well as lessons learned and recommendations for future applications of the methodology.[2] Specifically, it contains the following:

  - overview of the field test;
  - case studies from Ecuador, Turkey, Uganda, and Zimbabwe;
  - methodological lessons learned;

[1] The MAQ was a USAID Office of Population initiative in the 1990s to **M**aximize **A**ccess and **Q**uality in family planning and reproductive health services.

[2] Note: The compilation of country reports was published through the MEASURE *Evaluation* Technical Report Series.

- cost and practicality of methodology;
- recommendations for future applications;
- summary results from the short list of indicators.

- **Quick Investigation of Quality (QIQ): A Compendium of Instruments and Field Manuals from Five Countries**[3]

  This compendium includes the instruments and field manuals *actually* used in the QIQ field test for four countries: Ecuador, Turkey, Uganda, and Zimbabwe. It also includes the instruments and field manuals from Paraguay, which use a similar methodology.[4]

All of the above supporting documents from the QIQ field test are available through the MEASURE Evaluation Project. For further information, please contact:

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[3] The instruments and manuals used in each country are available at MEASURE Evaluation: www.cpc.unc.edu/measure/.
[4] Note: For some countries the instruments and field manuals are available in the local language.

ACKNOWLEDGMENTS

The original QIQ methodology and materials were developed by The MEASURE Evaluation Project and the Monitoring and Evaluation Subcommittee of the MAQ, with support from the United States Agency for International Development (USAID), with special thanks to James Shelton and Krista Stewart for promoting the initiative.

Several members of the original team collaborated in almost all aspects of the project: Ruth Bessinger, Gary Lewis, Tara Sullivan, Tim Williams, and Jane Bertrand. In addition, acknowledgement is given to those who assisted in the development of the instruments and/or the guidelines for testing them at the field level: Karen Beattie, Siân Curtis, Erin Eckert, Amparo Gordillo, Charles Katende, Abdelylah Lakssir, Robert Miller, Sangeeta Pati, Ernesto Pinto, William Sambisa, James Shelton, Krista Stewart, Ersin Topcuoglu, Ann Way and Marilyn Wilkinson.

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Finally, the authors thank Robert Magnani for preparing the chapter on sampling guidelines; Gary Lewis for assisting with the plan of analysis; Ruth Bessinger for developing Epi-Info screens for data analysis; Janet Rice for guiding the process of constructing the indices found in the plan of analysis; and Amy Tsui for technical advice throughout this process. Tara Sullivan was responsible for overseeing the final compilation of the user's guide, with assistance from Meghan McCarrier and Clayton Williams.

The second edition was possible with support from the USAID Office of Population & Reproductive Health. Technical review and updates at MEASURE Evaluation were provided by Janine Barden-O'Fallon and Brittany Schriver. Wayne Hoover and Denise Todloski helped make the guide more user friendly.

Module 1:
Overview of QIQ

Overview

The Quick Investigation of Quality (QIQ) was created in response to the need for a low-cost, practical means to routinely measure quality of care (QoC) in family planning services. Developed in the late 1990s with support from the USAID Office of Population, the QIQ benefited from the input of numerous cooperating agencies (CAs) in identifying a "short list" of QoC indicators, developing the set of instruments to measure them, and field-testing the instruments in four countries: Ecuador, Turkey, Uganda, and Zimbabwe. This work was spearheaded by the MEASURE *Evaluation* Project, in collaboration with the Monitoring and Evaluation Subcommittee of the MAQ.

The second edition of the user's guide is intended to make the methodology more accessible to program managers, evaluation specialists, and others interested in monitoring quality of care in family planning programs. The experience of the original field tests showed that the methodology is adaptable to other areas of reproductive health, which is an important consideration as more family planning programs are integrated with other health services. The updated volume contains the original elements of the user's guide, including an overview of the methodology, sampling guidelines, tips for training field staff, copies of the instruments (with modifications based on the field test experience), and guidelines for field personnel in collecting the data. It also includes an approach to presenting the results: a concise summary in numeric and graphic form of the short list of 25 indicators appropriate for policy makers and program staff.

Importance of Monitoring Quality of Care

The issue of quality of care in family planning and reproductive health programs (FP/RH) gained worldwide prominence in the early 1990s with the Bruce/Jain framework on quality of care (Kumar et al., 1989; Bruce, 1990). The framework outlines six elements that define quality of care in family planning programs: choice of methods, information given to clients, technical competence, interpersonal relations, follow-up and continuity mechanisms, and the appropriate constellation of services (Bruce, 1990). The importance of quality of care in FP/RH services was reinforced further at the 1994 International Conference on Population and Development held in Cairo. Here the focus of family planning efforts shifted to a more comprehensive "reproductive health" approach which calls for client-oriented, quality family planning services that empower a woman to make an informed choice in an environment of dignity and respect (Cohen and Richards, 1994). Recently, the FP2020 initiative (2014) placed further emphasis on the rights of women and girls to make informed decisions about their reproductive health.

The quality of care initiative struck a respondent chord in countries around the world. At the individual level, improved quality of care in family planning programs ensures women and men of respectful treatment by technically competent providers; it improves informed choice and empowers individuals and couples to make choices consistent with their reproductive intentions. At the aggregate level, improved quality should translate into greater contraceptive adoption, reduced method failure, and higher continuation rates, thus increasing contraceptive prevalence. Improved

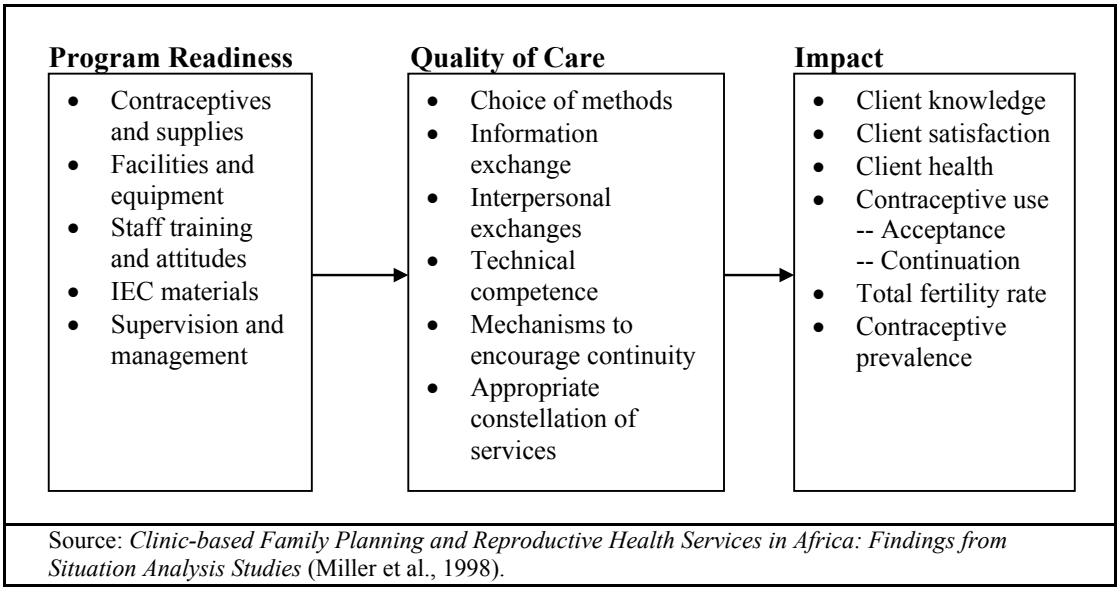
quality of care also may prompt people to act on their intentions to seek services in areas where there is fragile demand for contraception. From policy makers and managers at the country level to donor agencies at the international level, there is consensus that delivering quality services to clients seeking family planning and other reproductive health services is an important objective.

Initiatives to improve quality of care in FP/RH are supported at the policy level, given the current focus on the individual rights and needs of clients. Many programs are shifting from a focus on the number of clients served (which may lead to high discontinuation rates) to better serving the needs of their clients. In addition to effects at the individual level, higher quality services also may lead to changes in behavior in the catchment areas surrounding service delivery points as word gets around of improved quality of services provided (Jain, 1989). As a result, while putting the needs of the individual first, it is possible that programs can both satisfy the client and increase coverage.

Measuring quality on a routine basis is extremely important on several fronts. Spotlighting quality of care demonstrates to staff that it is an important component of the program and thus sets the bar for staff performance. In cases where an intervention to improve QoC is in place, quality of care can be measured over two points in time, not only to determine the effectiveness of the intervention, but also to inform future program strategies. Last, improved quality of care is of tremendous importance to consumers who are the first to benefit from better services and who may be further encouraged to meet their reproductive intentions as a result of quality services received.

The Quick Investigation of Quality (QIQ) was developed and tested to allow programs to monitor quality of care in family planning programs, and can be used to do so on a regular basis (e.g., every one to two years) if desired. An underlying premise for this methodology is that facility readiness affects the quality of care received by the client and that quality of care received may in turn affect impacts (e.g., contraceptive prevalence rates) (see Figure 1 below).

Figure 1. Quality of Care Conceptual Framework.



Source: *Clinic-based Family Planning and Reproductive Health Services in Africa: Findings from Situation Analysis Studies* (Miller et al., 1998).

Objectives of Field Test of Quick Investigation of Quality (QIQ)

The overall objective of the initiative was to develop and test a practical, low-cost methodology for monitoring quality of care (QoC) in clinic-based family planning programs in developing countries. Although programs at the field level have expanded beyond family planning to a wider range of services, this initial effort focused specifically on family planning, with the expectation that it could be adapted at the field level to other reproductive health services provided by the interested institution.

The specific objectives of the field test in selected countries were:

- To determine the feasibility of data collection;
- To test the comparability of results on selected variables obtained from two instruments: exit interview and client-provider observation;
- To experiment with a sampling strategy that requires fewer facilities to be visited but yields representative results;
- To determine the cost of collecting this type of data as a "stand-alone" exercise; and
- To produce data on the quality of care in a network of clinic facilities, for use in program improvement in a given country.

Short List of Quality of Care Indicators and Data Collection Instruments

Quality of care is a complex, multi-faceted issue. Consequently there are literally hundreds of indicators that can be used to measure quality, and the volume of data that can be generated in the name of measuring quality can be overwhelming. For this reason, the decision was made from the start to identify a "short list" of QoC indicators in the name of practicality. It was hypothesized that a facility performing well on key indicators would most likely perform well on similar indicators not measured by the instruments.

To arrive at a short list of QoC indicators, members of the CA community with a particular interest in quality of care and/or program evaluation were surveyed to identify those indicators of quality that they felt most directly affected quality **outcomes** in terms of client behavior. Three groups participated in this process: MEASURE *Evaluation* frontline staff attending the May 5, 1998 staff meeting, participants at the May 12-13, 1998 meeting of the MAQ initiative, and members of the Monitoring and Evaluation Subcommittee of the MAQ. The results are shown below in Table 1.

The short list of indicators can be measured by using three methods of data collection:

- **facility audit** with selected questions to the program manager;
- **observation** of client-provider interactions and selected clinical procedures;
- **exit interviews** with clients departing from the facility (and previously observed).

When used together, the three methods of data collection measure all of the short list indicators, in addition to other optional variables. Each instrument contributes information that may be used to create a more comprehensive picture of quality of care in a given set of facilities. The **facility audit** is used to determine the readiness of each facility to serve the client. Information is collected about types of services provided, types and amounts of supplies in stock, the condition of the facility, and the types of records kept. In the **observation**, a person with clinical training follows the client and evaluates the performance of the provider during counseling and clinical sessions, thereby collecting information on technical competence in counseling and clinical procedures (including some items the client might not be able to judge). The **client exit interview** collects information about the client's experience at a given health facility. This instrument is important because it provides information about the quality of services received from the client's perspective.

It is recommended that all three instruments be used to obtain the most complete picture of quality in a given network of facilities, since each provides a unique perspective not available from the others. Although there is considerable overlap on some items (as shown in Table 1), only the facility audit is able to measure the readiness of the facility to provide services. The observation of client-provider interaction is the only instrument that can assess technical competence in counseling and clinical procedures. And the client exit interview is the only source of data on the client's perspective. An example of how each instrument supplies information about QoC occurs in the case where due to lack of facility readiness (e.g., a facility has frequent stock-outs of a given method), and through no fault of the provider, a client does not receive her method of choice. Some organizations may not opt to use all three instruments, due to resource constraints, and updates to this tool allow projects to pull individual sections and tailor these sections to their measurement needs. It is, however, important to recognize the unique contribution of each tool to the overall assessment of QoC.

Table 1 below presents the short list of QoC indicators, as well as the instruments that can be used to collect each indicator. As mentioned above, this list served to guide the development of the instruments. Many of the indicators are similar to those used in the Situation Analysis (Miller et al., 1997), as are the three data collection instruments retained. However, in contrast to the Situation Analysis which is a more comprehensive set of instruments, the QIQ is intended to be sufficiently concise and practical that it can be repeated more frequently to track progress in improving quality of care in a given set of facilities.

Table 1. Short list of QoC Indicators Matched with QoC Instruments

Indicator Number	Indicator	Client Exit Interview	Observation	Facility Audit
	PROVIDER			
I-1	Demonstrates good counseling skills (composite)	✓	✓	
I-2	• Assures client of confidentiality		✓	
I-3	• Asks client about reproductive intentions (more children? when?)	✓	✓	
I-4	• Discusses with client which method s/he would prefer	✓	✓	
I-5	• Mentions HIV/AIDS (initiates or responds)	✓	✓	
I-6	• Discusses dual method use	✓	✓	
I-7	• Treats client with respect/courtesy	✓	✓	
I-8	• Tailors key information to the particular needs of the specific client	✓		
I-9	• Gives accurate information on the method accepted (how to use, side effects, complications)	✓	✓	
I-10	• Gives instructions on when to return	✓	✓	
I-11	Follows infection control procedures outlined in guidelines		✓	
I-12	Recognizes/identifies contraindication consistent with guidelines		✓	
I-13	Performs clinical procedures according to guidelines		✓	
	STAFF (other than provider)			
I-14	Treat clients with dignity and respect	✓		
	CLIENT			
I-15	Participates actively in discussion and selection of method (is "empowered")	✓	✓	
I-16	Receives his/her method of choice	✓	✓	
I-17	Client believes the provider will keep his/her information confidential	✓		
	FACILITY			
I-18	Has all (approved) methods available; no stockouts			✓
I-19	Has basic items needed for delivery of methods available through SDP (sterilizing equipment, gloves, blood pressure cuff, specula, adequate lighting, water)			✓
I-20	Offers privacy for pelvic exam/IUD insertion (no one can see)	✓	✓	✓

Indicator Number	Indicator	Client Exit Interview	Observation	Facility Audit
I-21	Has mechanisms to make programmatic changes based on client feedback			✓
I-22	Has received a supervisory visit in past __ months			✓
I-23	Adequate storage of contraceptives and medicines (away from water, heat, direct sunlight) is on premises			✓
I-24	Has state-of-the-art clinical guidelines			✓
I-25	Waiting time is acceptable	✓		✓

Description of Short List Indicators

Below is a description of each of the 25 short list indicators. Included in each description is an explanation of why the indicator is an important component of quality of care.

I-1 Provider demonstrates good counseling skills (composite)

An important aspect of delivering quality services is the demonstration of good counseling skills by the provider. Specific behaviors that improve communication and/or make the client feel comfortable include:

- Asking open-ended questions
- Encouraging clients to ask questions
- Treating clients with respect
- Seeing clients in private
- Discussing a return visit
- Asking clients about concerns with the method chosen
- Using a client record, and
- Assuring the client's confidentiality.

A provider demonstrates proficiency in counseling skills by ensuring the client's privacy and the confidentiality of the information exchanged, in addition to generally making the client feel at ease. Provider skill in this area is particularly important because a client may be more likely to continue contraceptive use if s/he feels comfortable with his/her interactions with clinic staff.

I-2 Provider assures client of confidentiality

Providers may assure clients of confidentiality by stating that the information disclosed during the counseling and clinical session will only be shared with relevant clinic staff. It is important that providers assure that the client-provider exchange will remain confidential so that the client will feel comfortable talking about sensitive topics and will be open and honest about personal issues. In small

communities in particular, clients may be more likely to seek services if they feel confident that their privacy will be protected.

I-3 Provider asks client about reproductive intentions (more children? when?)

It is important for providers to determine both the long- and short-term reproductive intentions of the client. Does the client want any children, or more children? In other words, is the client interested in limiting or spacing births of future children? Given the importance of informed choice, clients should be told how different methods could help them reach their reproductive goals. For example, a young woman who does not currently have children, but would like a child in the near future, should be told about re-supply methods such as the pill or injectables (although it is also useful to mention methods she may choose when she wants to stop having children). Obtaining information about a client's reproductive intentions will allow the provider to be responsive to client needs and desires.

I-4 Provider discusses with client which method s/he would prefer

Providers should talk with clients about which method they would prefer. Studies have shown that a client is more likely to continue use of a contraceptive if s/he receives the method s/he hoped to get before arriving at the facility. Also, by discussing with the client which method s/he would prefer, the provider is including the client in the decision-making process. Occasionally, there is a medically sound reason for the client **not** to receive the method s/he would like. Indicator # 16 measures whether s/he actually gets the preferred method.

I-5 Provider mentions HIV/AIDS (initiates or responds)

Given the burden of HIV/AIDS worldwide, it is extremely important that providers either initiate a discussion about HIV/AIDS or respond to questions about it. A provider should cover the following topics regarding HIV/AIDS:

- Explanation that contraceptive methods do not protect against HIV/AIDS (excluding the condom)
- Risks of HIV/AIDS if client has multiple partners, and
- Risks of HIV/AIDS if client's partner has multiple partners.

A provider, especially in countries with high HIV/AIDS prevalence, should discuss risk factors with the client.

I-6 Provider promotes dual method use

Providers should promote dual method use, especially in the case where HIV/AIDS prevalence is high. By promoting dual method use, providers educate the client about how HIV/AIDS is spread; a client will learn that the condom is the only contraceptive method that protects against both pregnancy and HIV/AIDS, and that s/he should use his/her current method in addition to the condom (if condom is not the current method) for protection against HIV/AIDS.

I-7 Provider treats client with respect/courtesy

Treating a client with respect includes (but is not limited to) greeting the client in a friendly manner and/or addressing the client by his/her full proper name. The provider may also show respect by maintaining eye contact. How a provider shows respect will be dictated by cultural norms. Regardless of the form it takes, it is important that a client leave the clinic feeling like s/he was treated well by the provider. A client that feels respected may be more likely to continue to seek services at the clinic, and consequently will be more likely to continue contraceptive use.

I-8 Provider tailors key information to the particular needs of the specific client

A good counseling and clinical session with a provider will include the determination of a client's needs based on his/her clinical history and reproductive intentions. A provider who is familiar with his/her client will know how much information to cover in the session. For example, if the provider is aware that the client has been using the pill for the past two years, s/he will not spend an inordinate amount of time explaining the side effects of the pill; rather, the provider may simply ask if the client is experiencing any complications and then move on to the next topic. It is important that a provider gauge the session according to the needs of the client. Ideally, a client will leave a visit feeling that s/he did not receive too little or too much information, but just the right amount.

I-9 Provider gives accurate information on the method accepted (how to use, side effects, complications)

In order for a client to use a method effectively s/he should know exactly how to use the method, and what side effects and complications may be experienced as a result of using the method. This indicator is particularly important for several reasons. First, the client must be told how to use the method so that it will be used correctly and consistently. Next, it is important to educate the client about any possible side effects that may be experienced. A client that is aware of the side effects will not be alarmed if s/he experiences them, and s/he will be informed about which side effects may be harmful to his/her health. Last, a client should also be informed about any possible complications. By describing the possible advantages and disadvantages of a particular method, a provider can help the client make an informed choice about the method s/he would like to use.

I-10 Provider gives instructions on when to return

Providers need to discuss with the client when to return for a follow-up visit. This indicator is extremely important because clients may need to return to the clinic to receive a new supply of their contraceptive method or, in the case of a clinical method, the provider may want to check for any signs of complications. Clients also should be advised of side effects that are harmful to their health so that they will know when to seek help. Clients should not be asked to come back for any unnecessary visits.

I-11 Provider follows infection control procedures outlined in guidelines

Providers need to follow infection control procedures in order to protect the client's health (as well as the provider's). Infection control procedures will vary by contraceptive method. Some general ways in which the provider may follow infection control procedures include:

- Washing hands
- Putting on gloves before exam
- Wiping contaminated surfaces with a disinfectant, and
- Decontaminating instruments and gloves.

Compliance with infection control procedures outlined in guidelines helps to ensure client and provider health and reflects the quality of services at a clinic.

I-12 Provider recognizes/identifies contraindications consistent with guidelines

Providers should check for and be able to recognize any contraindications that a client may have. Providers should have a checklist of potential contraindications by method and should go through each one with the client. If the provider fails to determine if the client has any contraindications, s/he is failing to provide quality services and threatening the health of the client.

I-13 Provider performs clinical procedures according to guidelines

For each contraceptive method, there are certain procedures that the provider should follow to ensure the health of the client. Contraceptive methods are most safely and comfortably administered if the provider follows certain steps. For example, if the client is receiving the injectable, the provider must ensure that the client is not pregnant. If the client is receiving a pelvic exam or an IUD, the provider should perform a bimanual exam without undue discomfort to the client.

I-14 Staff treats client with dignity and respect

Staff, other than the provider, is another important component of the quality of services received by the client. Since the staff is typically the first to see the client, they should make every effort to make clients feel comfortable and welcome in the clinic environment, including greeting clients when they arrive and answering any client questions. Clients that feel they are treated well by the staff may be more likely to access services at the clinic in the future and to continue contraceptive use.

I-15 Client participates actively in discussion and selection of method (is "empowered")

Ideally, clients should feel comfortable to ask the provider questions and to participate in the discussion surrounding the visit. A client may be considered empowered if s/he initiates some of the topics of discussion and if s/he actively seeks information from the provider.

I-16 Client receives his/her method of choice

A client may have a method of choice when s/he arrives at the clinic. If there are no contraindications for the client to receive that method, providers should give that method. If a client does not receive his/her method of choice due to provider preference for other methods, or because the method is not in stock, this is a reflection on the quality of services provided at the clinic. A client may prefer a method because s/he is familiar with it (i.e., other members of the family or community use it), which may make the client more likely to use it correctly and consistently.

I-17 Client believes the provider will keep his/her information confidential

It is important that the client not only be told by the provider that the information that s/he shares about himself/herself will be kept confidential (measured through Indicator # 2), but also that the client actually believes that it will be kept confidential. While a provider may *tell* a client that the information will be kept confidential, past experience may demonstrate that providers do not keep information about clients confidential. If a client is to access care and continue contraceptive use, it is important that s/he feel that the information that s/he discloses is kept confidential. This indicator is also important because a client's health may be jeopardized if s/he does not feel comfortable disclosing personal information (e.g., number of sexual partners or previous abortion).

I-18 Facility has all approved methods available; no stockouts

Facilities that are fully stocked with all contraceptive methods approved[1] for the site are prepared to provide quality services to clients. Facilities that have experienced one or more stockouts in the last six months are not able to consistently deliver services, and this may be a deciding factor for potential clients. If the facility does not consistently stock all methods, clients will either seek services at facilities that are reliable, or they may discontinue contraceptive use.

I-19 Facility has all basic items needed for the delivery of methods available through service delivery point (SDP) (e.g., sterilizing equipment, gloves, blood pressure cuff, specula, adequate light, and water)

Some items are essential for the safe delivery of contraceptive methods at a clinic. For example, for sanitary reasons, it is impossible to deliver high quality services if a facility does not have water available. In addition, a client's health is threatened if sterilizing equipment is not available at the facility. The QIQ list of essential equipment was not designed to be comprehensive, but rather to include key items that would serve as "markers" for the adequacy of equipment and supplies.

[1] Approved methods are those methods that the facility is licensed to provide. Some facilities are able to provide a range of methods (both re-supply and clinical methods), and others do not have properly trained personnel to deliver all methods (i.e., methods that require substantial clinical training to deliver).

I-20 Facility offers privacy for pelvic exam/IUD insertion

It is extremely important that a client feel that his/her privacy is protected during a visit to the clinic. Privacy may be protected by having a separate room for pelvic exams and IUD insertions, or by having an area closed in by a curtain for these types of exams.

I-21 Facility has mechanisms to make programmatic changes based on client feedback

Facilities that have mechanisms in place to both collect and act on client feedback demonstrate that they are sensitive to client needs. Facilities that are willing to make programmatic changes based on client feedback are more likely to have satisfied clients that return on a regular basis.

I-22 Facility has received a supervisor visit in __ months

While the amount of time between supervisory visits may vary from place to place, the principal behind the supervisory visit remains the same; someone should oversee facilities to ensure they are compliant with guidelines. Supervisory visits remind staff of the need to maintain a certain standard of quality in their work and can be used effectively to motivate staff to continue performing well.

I-23 Facility has adequate storage of contraceptives and medicines (away from water, heat, direct sunlight) is on premises

Medicines and contraceptives may be damaged by environmental factors such as water, heat, and sunlight; contraceptives may fail and medicines may not work as effectively. As a result, contraceptives and medicines need to be stored in such a way as to protect their integrity. Facilities that have appropriate storage of contraceptives and medicine are more likely to have satisfied clients because their products will be more reliable.

I-24 Facility has state-of-the-art guidelines

Facilities that have state-of-the-art guidelines demonstrate that accepted standards are in place. Acceptable procedures and practices are more likely to occur if clinic personnel are able to easily refer to the guidelines. State-of-the-art guidelines ensure that the recommended practices and procedures are based on the most up-to-date research on the topic of interest. Even if a facility does have guidelines, this does not guarantee good service (they may not even be read); however, they are a minimum requirement for good service delivery.

I-25 Waiting time is acceptable

An acceptable waiting time may vary from culture to culture. In general, a waiting time of less than 30 minutes may be used as a guideline for what is acceptable. If waiting times are in excess of 30 minutes, the clinic is not being respectful of the client and discourages use of this facility in the future.

QIQ Indicators Matched with Elements of Bruce/ Jain Framework[2]

Although the QIQ was originally designed to measure those indicators thought to have the greatest effect on client outcomes, it also has indicators to measure five of the six elements of the Bruce/Jain framework: choice of methods, information given to clients, technical competence, interpersonal relations, and mechanisms to ensure continuity[3].

However, the literature shows that some indicators correspond to multiple elements of the Bruce/ Jain framework. That is, some studies use one indicator to measure a given element of the framework whereas others link the very same indicator to a different element. Below, the short list of QIQ indicators are linked to the Bruce/Jain elements as found in the literature.

[2] Bruce, J. 1990. "Fundamental Elements of Quality of Care: A Simple Framework." Studies in Family Planning. (21) 2: 61-91.

[3] Note: An appropriate constellation of services, as originally defined by Bruce and Jain, did not figure on the short list of indicators.

QIQ Indicators matched with Bruce/Jain elements as found in the literature[4]

QIQ Indicator	Choice	Information	Technical Competence	Interpersonal	Follow-up
I-1: Provider demonstrates good counseling skills		✓		✓	
I-2: Provider assures client of confidentiality		✓		✓	
I-3: Provider asks client about reproductive intentions (more children? when?)		✓		✓	
I-4: Provider discusses with client which method s/he would prefer	✓	✓			
I-5: Provider mentions HIV/AIDS (initiates or responds)		✓			
I-6: Provider discusses dual method use		✓			
I-7: Provider treats client with respect/courtesy				✓	
I-8: Provider tailors key information to the particular needs of the specific client		✓		✓	
I-9: Provider gives accurate information on the method accepted (how to use, side effects, complications)		✓			
I-10: Provider gives instruction on when to return		✓			✓
I-11: Provider follows infection control procedures outlined in guidelines			✓		
I-12: Provider recognizes/ identifies contraindications consistent with guidelines			✓		
I-13: Provider performs clinical procedures according to guidelines			✓		
I-14: Staff treats client with dignity and respect				✓	
I-15: Client participates actively in discussion and selection of method (is "empowered")				✓	
I-16: Client receives his/her method of choice	✓				
I-17: Client believes the provider will keep his/her information confidential				✓	
I-18: Facility has all (approved) methods available; no stock outs	✓				
I-19: Facility has basic items needed for delivery of methods available through facility (sterilizing equipment, gloves, blood pressure cuff, specula, adequate lighting, water)			✓		
I-20: Facility offers privacy for pelvic exam/IUD insertion (no one can see)				✓	
I-21: Facility has mechanisms to make programmatic changes based on client feedback					
I-22: Facility has received a supervisory visit in past __ months			✓		
I-23: Facility has adequate storage of contraceptives and medicines (away from water, heat, direct sunlight) on premises			✓		
I-24: Facility has state-of-the-art clinical guidelines			✓		
I:25: Waiting time acceptable				✓	

[4] Note: There are QIQ short list indicators that do not link to the Bruce/Jain framework.

Methodological Issues

There are several methodological issues that should be taken into consideration during the training, implementation, and the analysis phase of the study.

Reliability of observations

The reliability of observations may be called into question if there is low inter-rater reliability. This issue is best addressed during training, where multiple observers can observe and rate the same client-provider sessions in a role-play situation or through videotapes of actual counseling sessions. Results can then be compared, and trainers can provide clearer guidance as to how to code items on which there is low inter-rater reliability.

Hawthorne Effect

The Hawthorne Effect results from the presence of an observer in the room during the counseling and clinical sessions with the provider; the added presence of the observer may cause the client and the provider to act differently than they would if they were alone (Rossi and Freeman, 1993). For example, the provider may be on his/her best behavior when a researcher is present. The Hawthorne Effect may be partially mediated by training the observer to be as unobtrusive as possible (e.g., dressed in a lab coat with proper identification, same sex as the client, etc.). Although some providers will perform better while being observed, the experience to date suggests that observation still is an effective means of identifying shortcomings in provider performance. If a provider does not know a certain fact or is not competent at a certain procedure, the presence of the observer will not change that reality.

Recall bias

Clients may not remember the sequence and content of events during the counseling and clinical sessions. For this reason, the client exit interview contains only a limited number of questions (e.g., which method did you want when you came here?). The results of the field test showed a high degree of consistency between the reports of the observer and of the client as to what occurred during the counseling session, suggesting that client recall on these items was satisfactory.

Courtesy bias

It has been shown that clients are likely to report that they feel satisfied with the services that they have received and will not speak negatively about the clinic or clinic staff during exit interviews. Hence, results from the client exit interview tend to be positively skewed on the question of satisfaction. This issue may be addressed by training interviewers to explain to the client that what they say in the interview will not jeopardize their care at the clinic. Given the expectation of courtesy bias, the exit interview also contains a number of items that require more "objective" answer (e.g., did the provider explain to you how to use the method effectively?). Results from the client exit interviewer should be interpreted with the understanding that they may be positively biased.

Ethical Issues

The QIQ involves collecting information from clients and observing the client-provider interaction. The rights of both the client and the provider must be considered when designing and implementing the study. Clients should be asked for their informed consent before they are observed and before they are interviewed in the client exit interview. Providers also should be asked for their consent before they are observed. Participants need to be aware of any risks and/or benefits of the study. They should be informed that they do not have to participate in the study and that if they choose not to participate, it will not affect their care at the facility in any way. In addition, clients must be assured that the information collected will be kept confidential. This informed consent may be administered verbally, or the client or provider may read it.

In addition to informed consent, protocols must be developed to determine how forms will be stored to preserve confidentiality and how observers should react if they witness improper (especially life-threatening) clinical procedures. In the latter case there is a delicate balance between protecting the safety of the client and jeopardizing future research at that site. A typical method to preserve confidentiality is the use of code numbers to identify facilities, providers, and clients, rather than names. The lists linking the facility code numbers to the facility names should be stored separately from the questionnaires and access to the list should be restricted to study personnel. In most cases, it will not be necessary to collect the names of the providers and clients. If names are collected, they too should be kept separately from any identifying codes and not be released to non-study personnel. Particular care must be taken to protect the confidentiality of clients and providers in small facilities where they could be more easily identified. All study staff should be informed that they should not discuss the results of the interview with anyone, and this rule should be strictly enforced.

The procedures described above represent good practices in any study. In addition, a QIQ must comply with any relevant regulations governing ethical research procedures. The exact nature of these regulations will vary across countries, institutions, and funding bodies. For example, the study may need to be approved by an Institutional Review Board (IRB), or receive clearance from the Ministry of Health or another organization. Whether or not a QIQ needs to be approved in this way will depend on many factors including whether it is considered to be part of a routine data collection system or a separate research study. In general, ethical reviews and approvals are not required for routine data collection. The relevant regulations should be checked when designing a QIQ to ensure that the study is in full compliance.

Module 2: Guidelines for Sampling and Training of Field Personnel

Sampling Guidelines[5]

Overview

An important aspect of undertaking surveys to monitor the quality of family planning service delivery in a program is the method used to choose samples of facilities, service providers, and clients from whom to gather data. Unless sampling is done with some measure of scientific rigor, the findings from monitoring surveys might well be misleading. This section considers sampling procedures for four different situations or scenarios. They are:

Scenario 1 The Ministry of Health in Country X (or other large national program) is interested in monitoring the quality of family planning services at MOH facilities

Scenario 2 A program with a limited number of facilities (e.g., less than 50) is interested in monitoring the quality of family planning services in its network of clinics

Scenario 3 A program is interested in comparing intervention to non-intervention areas

Scenario 4 A low-contraceptive prevalence country would like to monitor the quality of services under any of the above scenarios

The discussion of each scenario covers the following issues:

- Primary measurement objective;
- Sampling frame requirements;
- Sample size requirements;
- Sample selection procedures;
- Estimation (weighting and variance estimation); and
- Sampling plan for subsequent rounds.

The discussion of sampling schemes is based upon the following basic assumptions or parameters about the surveys themselves:

1. Data are to be gathered annually or every two (or more) years;
2. The data are to be gathered through observations of service transactions and client exit interviews during the course of visits to facilities;
3. Data collection is to be undertaken by a research team (or teams) from the central program level;
4. he data collection exercise is intended to be relatively low cost; and
5. It is desirable to make formal inferences regarding service quality in larger service delivery system from sample observations. As a result, probability sampling is desirable.

[5] Note: This section was prepared by Dr. Robert Magnani, Tulane University.

NOTE TO READERS:

This chapter requires some background in concepts of sampling, statistical significance, weighting of data, and other concepts familiar to statisticians. It is not expected that these concepts would be familiar to program managers (unless they have had special training in these topics).

However, all readers are encouraged to read the one-page Overview and identify which type of "scenario" best describes their own case. If it is **Scenario #2** (in which the network of clinics to monitor is small enough that it is feasible to include all in the study), then it may not be necessary to obtain additional statistical consultation. A member of the research team can follow the instructions relevant to **Scenario #2** for selection of actual clients at those facilities.

By contrast, **Scenario #1** calls for conducting the QIQ for a network of clinic facilities that is far too large to include every facility (e.g., Ministry of Health clinics in most developing countries). In this case, it would be useful to obtain the services of a person with some statistical training to develop the sampling framework for the study.

Scenario #3 (comparing QoC in a network of clinics: intervention versus non-intervention areas) may also require additional statistical consultation. **Scenario #4** (monitoring QoC in low-prevalence countries) is relatively straightforward if the network of clinics is small enough to take all of them. In contrast, additional statistical assistance may be needed if the network of clinics is sufficiently large to require selecting a sample of them (similar to **Scenario #1**).

Once the sample is selected, the data collection is well within the means of service delivery organizations with limited research experience. We encourage users of this guide to seek help on the sampling, if necessary, to ensure that it is completed correctly and that the study will yield valid results.

Scenario 1: The Ministry of Health in Country X (or other national program) is interested in monitoring the quality of family planning services at MOH facilities

Measurement objective

In Scenario 1, a large national program (e.g., a Ministry of Health) desires to be able to systematically monitor changes (hopefully improvements) in the quality of family planning services provided through periodic facility surveys. It is assumed in this scenario that the number of facilities in the program or service delivery system is sufficiently large that obtaining measurements from each facility is infeasible (note: Scenario 2 covers the case of programs with modest numbers of facilities). The primary measurement objective is to assess the level of service quality and changes over time from a sample of facilities such that inferences to the entire system may be made from the sample measurements or observations.

Sampling frame requirements

The following information is needed to develop an appropriate sampling frame for this scenario:

1. A list of all facilities in the system or program that provide family planning services, ordered by type (i.e., hospitals, health centers, health posts, etc.) and geographical location; and
2. Information on client volume (i.e., number of FP service visits last year) for each facility. This information will normally be obtained from service statistics.

Table 1 provides an illustrative sampling frame layout.

Two further issues about sampling frames merit attention. First, it will be noted that some of the service quality indicators pertain to new family planning clients making their first service visit to a facility, while others pertain to repeat clients or continuing users. A question that might arise is whether counts of new acceptors or continuing users should be used as measures of size in sampling frames? In view of the definitional inconsistencies between "new acceptors" and "continuing users" in some settings, and the fact that the volume of clients of different types is likely to be correlated, it is suggested that the total number of family planning visits or clients seen during a prior period be used as a measure of size for sampling purposes. Such an aggregate or overall service volume indicator should satisfy the sampling needs for all service quality indicators.

Secondly, it is acknowledged that the accuracy of service statistics is often not as high as would be desired. If the service statistics from which measures of size for use in sampling are derived are deemed to be of poor quality, does this invalidate their use? The answer to this question is generally no. Even if service statistics are seriously flawed (for example, over- or under-state the "true" volume of family planning clients by 30-50%), if some facilities are serving 2-5 times the number of clients than others (a common occurrence), then there is still much to be gained by using the flawed service data and choosing facilities following procedures described later in this guide.

Table 1. Illustrative sampling frame layout

Stratum 1 (hospitals)
- Province 1
  - Urban Facility 1
  - Urban Facility 2
  - .
  - .
  - .
  - Urban Facility n
  - Rural Facility 1
  - Rural Facility 2
  - .
  - .
  - .
  - Rural Facility n
- Province 2
  - Urban Facility 1
  - Urban Facility 2
  - .
  - .
  - .
  - Urban Facility n
  - Rural Facility 1
  - Rural Facility 2
  - .
  - .
  - .
  - Rural Facility n
- Province n
  - Urban Facility 1
  - Urban Facility 2
  - .
  - .
  - .
  - Urban Facility n
  - Rural Facility 1
  - Rural Facility 2
  - .
  - .
  - .
  - Rural Facility n

Facilities in other strata (e.g., health centers, health posts, etc.) are to be arranged in a similar fashion.

Sample size requirements

Number of observations/client exit interviews needed

As the primary purpose of the monitoring exercise is to measure changes on selected indicators of service quality over time, the key sample size question is how many service observations and client exit interviews will be needed in order to reliably measure changes of a specified magnitude on key indicators. For example, it might be desired to be able to measure changes between survey rounds on selected key indicators (assumed here to be measured as proportions) of 10 percentage points with 95% significance and 90% power. The concepts of statistical significance and power are defined in the box below.

Technical note on statistical significance and power

Significance – the desired degree of certainty that an observed change on an indicator between two surveys could not have occurred by chance. For example, a significance level of 95% means that an observed change would be expected to have occurred by random chance alone only 5 times in 100 (and is thus highly likely to be a "real" change).

Power – the desired degree of certainty of detecting a change on an indicator of a specified size between two surveys, had one actually occurred. For example, by choosing a sample size that has 90% power, the chances of failing to detect a change on an indicator of a given size (e.g., 10 percentage points) had one actually occurred would only be 10 in 100 (or 1 in 10).

Table 2 indicates the number of service observations and client exit interviews that would be required per survey round in order to measure changes of 10 and 15 percentage points, respectively, between any two survey rounds for different combinations of significance and power. Changes of 10 and 15 percentage points are recommended as the minimum changes that programs should try to measure, as measuring smaller changes would require sample sizes that are likely to be too large for most programs for periodic monitoring surveys.

The sample sizes shown in Table 2 assume values on key service quality indicators of .50 in the initial survey round. This is a "worst case" scenario with regard to sample size requirements, as the largest sample sizes for surveys are required to measure indicators in the .40-.60 range. Accordingly, the sample sizes shown in Table 2 will be sufficient for all surveys irrespective of the actual starting values of key indicators. In other words, if a program has no information on the initial levels of key service quality indicators at the outset of a monitoring program, the sample sizes shown in Table 2 should be used. If information is available suggesting that the starting values for key indicators are very different from .50 (in which case smaller sample sizes would suffice), Table 3 may be used to choose a sample size.

Table 2. Number of service observations or client exit interviews needed per survey round to measure changes in key indicators of 10 and 15 percentage points, respectively, for given levels of statistical significance and power

Level of Statistical Significance and Power Desired	Magnitude of Change to Be Detected	
	10 Percentage Points	15 Percentage Points
95% significance, 90% power	841	367
95% significance, 80% power	607	266
90% significance, 90% power	646	282

Note: assumes an initial indicator value of 50% and a design effect due to cluster sampling of 2.0

Table 3. Sample size requirements for selected combinations of values of service quality indicators at the time of an initial (P_1) and follow-up (P_2) survey, significance, and power

		Significance level / Power			
P_1	**P_2**	**95/90**	**95/80**	**90/90**	**90/80**
.10	.20	432	312	331	228
.10	.25	216	156	165	114
.20	.30	636	460	485	336
.20	.35	299	216	229	158
.30	.40	773	558	594	408
.30	.45	352	255	270	186
.40	.50	841	607	646	444
.40	.55	375	271	288	198
.50	.60	841	607	646	444
.50	.65	367	266	282	194
.60	.70	773	558	594	408
.60	.75	329	238	253	174
.70	.80	636	460	485	336
.70	.85	261	189	200	138
.80	.90	432	312	331	228
.80	.95	163	118	125	86

P_1 = value of indicator at the time of the initial survey; P_2 = expected value of an indicator at the time of a second (follow-up) survey. Sample sizes shown assume a design effect of 2.0 and are based on one-tailed significance tests.

It will be noted that the sample sizes shown in Table 2 and in Table 3 assume a design effect (deft) of 2.0. The deft compensates for the use of cluster sampling in the calculation of sample size requirements. A value of 2.0 means that the sample gathered using cluster sampling would have to be twice as large as a sample gathered using simple random sampling.

The deft value of 2.0 used in Table 2 and Table 3 is a default value that is often used in the absence of information on the actual degree of clustering. Because the quality of services within facilities is likely to be highly correlated, a deft of 2.0 may be too low, and thus the above sample size requirements should be viewed as minimums. Should the results of the initial round of monitoring surveys indicate significantly higher design effects, the sample sizes used in subsequent survey rounds should be increased as necessary.

Number of service observations/client interviews per facility

One of the key sample size decisions to be made is how many client observations/interviews should be obtained from each sample facility. One strategy would be to obtain a fixed number per facility; for example, 5 or 10. The primary advantage of this strategy is that it equalizes the workload across facilities, making survey operational planning somewhat simpler. The primary disadvantage is that it might take a considerable amount of time to accumulate observations and client exit interviews at facilities where client volume is low. For example, if a facility sees, on average, one family planning client per day and the target for each facility is set at 10, it would take 10 days (more or less) in order to gather the required number of observations/client interviews. This has been a problem in a number of prior facility surveys.

An alternative strategy is to obtain as many observations/interviews as possible during a fixed data collection period (e.g., one day) and allow the volume of data collected to vary by facility. It will be noted that having differing numbers of observations/interviews across facilities does not pose a bias problem, as the data can be weighted to take into account differing probabilities of selection.

Recommended course of action – using fixed quotas per facility is likely to be impractical unless the data collection is done by local researchers (for whom remaining at a facility until a quota of observations/interviews has been obtained will be less of a problem than for central-level researchers). The "take-all-on-a-randomly-chosen-day" strategy is the more feasible option, but allowance needs to be made for the possibility that no family planning clients will appear at facilities on some days. This may be done by making conservative assumptions about the expected daily client volume and increasing the number of facilities to be included in the sample. This will be especially important in the initial round of data collection in each country. Should the concern prove unfounded, the number of sample facilities to be chosen in subsequent survey rounds could be adjusted downward.

Number of sample facilities

Under the "take-all" strategy, the number of sample facilities to be chosen is driven by the expected number of client visits per facility per day. This latter statistic is calculated as follows:

Expected visits = sum of FP client visits across all facilities / no. of facilities * avg. no. of days that facilities were open for FP services

For example, suppose that all program facilities (n=235) reported a total of 300,000 FP visits during the previous year. If facilities were open for FP services an average of 220 days, the expected number of FP visits per facility per day would be:

Expected visits = 300,000 / 235 * 220 = 5.80

Thus, if the target sample size were to be 600 observations/interviews and data were to be collected for one day at each facility, 103 facilities would have to be included in the survey. Alternatively, the number of facilities that would need to be visited could be reduced by increasing the length of the observation period from one to two days.[6]

Sample design

The proposed sampling scheme, a stratified, two-stage cluster design, attempts to reduce the number of facilities that will have to be visited in any survey round by choosing facilities with probability proportional to client volume. This has the effect of favoring facilities that have large numbers of clients over those with small numbers of clients. While this could result in bias if there were to be a correlation between service quality and client volume (a distinct possibility), this potential bias is compensated for by weighting the sample observations prior to analysis.

The steps in the sample selection procedure are as follows:

1. Prepare a geographically ordered list of provinces or comparable sub-divisions
2. Choose a sample of provinces/comparable sub-divisions using systematic sampling with probability proportional to the number of facilities offering family planning located in each province. The number of provinces to be chosen will depend upon the resources available for the monitoring activity, but as a practical matter should not exceed 20-25% of the total number of provinces. The steps involved in systematic sampling with probability proportional to size (PPS) are summarized in Table 4, and an illustrative application is provided in Table 5.
3. Stratify facilities into groups according to type. Within each facility-type stratum, the list of facilities should be ordered by province, and within provinces by urban-rural location.
4. Select a sample of facilities from each stratum using systematic sampling with probability proportional to client volume. The total number of facilities to be chosen from each stratum will depend upon the expected daily client volume and the sample allocation to the stratum. The total target sample size should be allocated proportionally to client volume in each stratum. So, for example, if in a given setting 10% of client volume is handled at hospitals, 30% at health centers, and 60% at health posts, the sample would be allocated to strata in these same proportions.

[6] Note: This average could be calculated by major type of facility or for within strata sampling.

For example, suppose that n=600 client observations/interviews were needed in a setting where 10% of FP clients are seen at hospitals. Thus, n=60 observations/interviews would be needed from hospitals. If service statistics from the prior year were to indicate that hospitals see on average 5 FP clients per day, a total of n=12 hospitals would need to be visited.

Table 4. Steps in the selection of a systematic-random sample with probability proportional to size (PPS)

(1) Prepare an ordered list of sampling units (e.g., provinces or facilities -- see text for instructions on ordering) with a corresponding measure of size for each (e.g., number of facilities offering family planning services, number of family planning clients or visits during the prior year);

(2) Starting at the top of the list, calculate the cumulative measure of size and enter these figures in a column next to the measure of size for each sampling unit;

(3) Calculate the sampling interval (SI) by dividing the total cumulative measure of size for the stratum (M) by the number of facilities to be selected (a); that is, SI = M/a;

(4) Select a random number (RS) between 1 and (SI). Compare this number with the cumulated measure of size column. The sampling unit within whose cumulated measure of size the number (RS) falls is the first sample unit;

(5) Subsequent units are chosen by adding the sampling interval (SI) to the number identified in step (4); that is RS + SI, RS + 2SI, RS + 3SI, etc;

(6) This procedure is followed until the list has been exhausted.

Estimation

Weighting

Because client observations/interviews are to be chosen with unequal probabilities, the survey data will be non-self-weighting, and will thus need to be weighted prior to analysis in order to produce unbiased estimates. The sampling weights to be applied to sample observations / interviews from a given facility will be equal to the inverse of their probability of selection. All observations / interviews obtained from a given facility will receive the same weight.

Under the proposed sampling scheme, the probability of selection of a given service transaction or client for an exit interview is:

$$P_{ijk} = (a * M_i/M) * (b_{ij} * C_{ijk}/C_{ij.}) * (d_{ijk}/D_{ijk})$$

Where:

P_{ijk} = probability that a family planning service visit at facility k of type j in province i was chosen for observation/exit interview;
a = number of provinces chosen for the survey;
M_i = measure of size (i.e., number of facilities offering FP services) for province i;
M = total number of facilities offering FP services in province i;
b_{ij} = number of facilities of type j chosen for the survey;
C_{ijk} = client volume last year at facility k of type j;
$C_{ij.}$ = total client volume last year at all facilities of type j offering FP services in sample provinces;
d_{ijk} = number of days of data collection at facility k; and
D_{ijk} = number of days that facility k was open for family planning services last year.

The appropriate sampling weight for observations/interviews at facility k is thus:

$$W_{ijk} = 1/P_{ijk}$$

Note, however, that when sampling weights are applied to survey data using some standard computer software packages (e.g., SPSS), the number of sample observations will be inflated and will thus imply a larger sample size than was actually the case. As a result, statistical tests for changes in indicators over time will be based upon incorrect sample sizes, and misleading conclusions might result.

To compensate for this, standardized weights should be used. Standardized weights assign a weight to each sample observation that reflects its relative probability of selection in comparison with other sample observations, but do not change the overall survey sample size. Standardized weights (W_{ijk}') for sample observations from facility k are calculated as follows:

$$W_{ijk}' = W_{ijk}\, n_{ijk} \,/\, \Sigma\, W_{ijk}\, n_{ijk}$$

Where:

W_{ijk} = sampling weight for facility k of type j in province i; and

n_{ijk} = number of observations/interviews receiving weight W_{ijk}.

Variance estimation

In assessing the statistical significance of observed changes in service quality indicators over time, it is important that account be taken of the design effects resulting from the use of cluster sampling in the calculation of standard errors of survey estimates. If the design effects are not accounted for, changes that were not statistically significant may be incorrectly judged to have been significant.

Many of the commonly used statistical packages assume simple random sampling, and thus produce incorrect estimates of standard errors. Among the packages that properly handle cluster sample designs are STATA, SUDAAN, PC-CARP, CLUSTERS, EPI-INFO, SAS, and SURVEY.

Sampling plan for subsequent survey rounds

Given that monitoring is to be undertaken on a continuing basis, a sampling plan for subsequent survey rounds will be needed. One option would be to retain the same sample of facilities. The primary advantage of this option would be, to the extent that service quality measures for facilities are correlated over time, to reduce variance in the measurement of changes in indicators over time. Alternatively, a new sample of facilities could be chosen in each survey round. The primary advantage of this option would be to minimize the chances of continually visiting the same facilities influencing service delivery performance differentially at those facilities, such that inferences concerning improvements in service quality would be misleading/biased.

A compromise solution often used in continuing survey programs is to retain a fixed proportion of sample sites from one survey round to another and replace the remaining sites with a sample of newly chosen sites. For example, 50% of sample sites might be retained between rounds 1 and 2 and the other 50% replaced. In round 3, the sample sites remaining from the first survey round would be replaced by a new sample of sites and the new sites for round 2 retained, and so on.

Scenario 2: A program with a limited number of facilities (e.g., less than 50) is interested in monitoring the quality of family planning services in a network of clinics

Measurement objective

Scenario 2 differs from Scenario 1 in that a smaller number of facilities comprise "the program" whose services are to be monitored. It is assumed here that the number of program facilities is sufficiently small that they can all be covered in service quality surveys. Programs with more facilities than can feasibly be included in service monitoring surveys (even if they are not national in scope) will require that a sample of facilities be drawn, and the appropriate sampling guidelines would be those for Scenario 1 (although the initial stage of sampling provinces may not be needed).

The primary measurement objective for Scenario 2 is the same as for Scenario 1: to obtain measurements of service quality and changes in service quality indicators over time such that inferences to the entire program or service delivery system may be made from the sample measurements or observations. However, since data are to be gathered from all program facilities, the validity of inferences to the entire program or service delivery system will depend entirely on how service transactions and clients are sampled within program facilities.

Sampling frame requirements

As all program facilities are to be included in monitoring surveys under this Scenario, a formal sampling frame is not needed. All that is needed is a list of facilities comprising "the program."

Sample size requirements

Number of observations/client exit interviews needed

The sample size requirements in terms of numbers of service observations and client exit interviews needed under Scenario 2 are identical to those for Scenario 1. The reader is referred to the discussion of this topic and sample size tables under Scenario 1.

Number of service observations/client interviews per facility
As all program facilities are to be included in monitoring surveys under this Scenario, the number of service observations and client exit interviews to be obtained from each sample facility will depend upon:

- the total number of sample observations/interviews needed,
- the number of facilities in the program, and
- the strategy chosen to sample observations/interviews at facilities.

As in Scenario 1, there are two options for sampling observations/interviews at program facilities: (1) obtaining a fixed number or quota per facility (e.g., 10 per facility) and (2) observing all service transactions and interviewing all clients at program facilities during a fixed data collection period (e.g., one or two days). The advantages and disadvantages of these options were discussed in connection with Scenario 1. For reasons outlined earlier, the "take-all" strategy is generally the more feasible option. For Scenario 2, this option provides the added advantage that the survey data will be self-weighting, and sampling weights will not have to be used during analysis.

To illustrate, suppose it was determined that n=600 observations/interviews were needed to monitor changes in service quality in a program that has 10 facilities serving an average of 30 family planning clients per day (in total, for all facilities combined). Thus, a total of n=20 observation-days would be needed to reach the target number of observations/interviews. Since there are n=10 facilities in the program, each facility would have to be visited for two days each.

Sample design

The proposed sampling scheme for this scenario is a one-stage cluster design. Each facility is treated as a "cluster," as observations within facilities are likely to be correlated with regard to service quality. Under this design, all facilities are to be visited for a specified number of days, and all service transactions observed and all clients interviewed on the day(s) chosen.

Estimation

Weighting

Because (1) all program facilities are included in the sample and (2) each facility is to be visited for the same length of time under the proposed sample design for this scenario, all service transactions observed and clients interviewed will have the same overall probability of selection. The survey data will thus be self-weighting, and no further action will be required during analysis in order to produce unbiased estimates.

Variance estimation

Since the proposed sample design for this scenario is a cluster design, it will be necessary to take into account the design effects resulting from the use of cluster sampling in the calculation of standard errors of survey estimates. See the discussion of this topic for Scenario 1 for a list of computer software packages that correctly handle variance estimation for cluster sample designs.

Sampling plan for subsequent survey rounds

Since all program facilities are to be included in all surveys under this scenario, there is not an issue over whether to retain or replace sample facilities in subsequent survey rounds – all facilities should be visited in subsequent rounds.

Scenario 3: A program is interested in comparing intervention to non-intervention areas

Measurement objective

Scenario 3 is a more ambitious undertaking than the previous two scenarios. In this scenario, the desire is to measure the impact of service quality improvement interventions by comparing changes in service quality in "program" or "intervention" facilities with those for a set of similar non-program or "comparison" facilities. Impact is measured as the difference between changes on indicators between "intervention" and "comparison" facilities. It will be noted that this scenario requires that service quality surveys be undertaken at two or more points in time in both intervention and comparison facilities.

Sampling frame requirements

Sampling frame requirements will depend upon (1) the number of facilities in the "program" of interest and (2) how comparison facilities are to be chosen. The sampling frame requirements for program facilities are the same as outlined for Scenarios 1 and 2, depending upon whether it is feasible to include all program facilities in monitoring surveys. If all facilities can be included, the sampling frame requirements are as outlined for Scenario 2. If including all program facilities is not feasible, the requirements are as outlined for Scenario 1.

In order to provide valid measures of program or intervention impact, it is important that the "comparison" facilities be as similar as possible to "program" or "intervention" facilities with regard to all factors other than the intervention to improve family planning service quality. If the intervention of interest is being implemented within a certain geographic area (e.g., a district, province, or region), appropriate comparison facilities might consist of similar facilities located in a nearby area that is as comparable as possible socio-economically and culturally as the area in which the program is working. This could include facilities operated under the same authority (i.e., the Ministry of Health, the same NGO, etc.) in which the service quality intervention being assessed has not yet been introduced. If the program is not confined to a specific geographic area, comparison facilities are probably best chosen by matching facilities with regard to characteristics such as location, services offered, the length of time the facility has offered family planning services, etc.

With regard to sampling frames for comparison facilities, if matching is to be used to identify appropriate comparison sites, the facilities chosen via the matching process will comprise the set of facilities to be included in the monitoring surveys, and no further sampling frame development work will be needed. If comparison facilities are to be chosen by taking a sample of facilities in a comparison area (e.g., an adjacent district, province, or region), a complete list of facilities in the comparison area and service statistics on client volume for a recent period for each facility will be needed. Note, however, that if the number of facilities in the comparison area is small enough that all facilities can be included in the sample, it will simplify the sampling process to just include them all in the survey(s).

Sample size requirements

Number of observations/client exit interviews needed

In Scenarios 1 and 2, the number of service observations and client exit interviews needed per survey round depended upon the magnitude of change to be detected on key indicators. In Scenario 3, the required sample size depends upon the magnitude of differential change between "intervention" and "comparison" facilities to be detected. To illustrate, suppose that key service quality indicators improved by 15 percentage points in program facilities over a three-year period, but indicators of service quality also improved in comparison sites over the same period by 5 percentage points. A sample of program and comparison sites of sufficient size to be able to detect a change of 10 percentage points (the differential magnitude of change) would thus be needed in order to be able to conclude that the changes in program facilities were larger than in comparison facilities. The appropriate sample size for this situation would be the same as for measuring a change of 10 percentage points as shown in Table 2.

Operationally, it is necessary under this scenario to make allowance for the possibility of improvements in service quality in comparison facilities when estimating sample size requirements, as larger sample sizes will be needed than if the survey measurement objective were only to measure changes over time for program facilities (as in Scenarios 1 and 2). The recommended procedure is to first determine an "expected" magnitude of change on key indicators for program facilities, then subtract out an allowance for improvements in comparison sites. The resulting differential magnitude of change would be the figure used to choose a sample size from Table 2. It will be noted that in this Scenario the sample size figure obtained indicates the number of service observations and client exit interviews that will be needed in both program and comparison facilities in each survey round.

Number of service observations/client interviews per facility and number of facilities

The major considerations involved in determining the number of service observations and client exit interviews to be obtained per facility and number of facilities to be included under this scenario are the same as for Scenarios 1 and 2. If all program facilities are to be included in the survey, the relevant guidelines are those for Scenario 2. If it is necessary to sample program facilities (because covering all such facilities is infeasible), the guidelines for Scenario 1 should be followed.

Sample design

Sampling "intervention" facilities

The sample selection procedures for "intervention" facilities in Scenario 3 will depend upon whether all such facilities can be included in the survey. If all facilities cannot be surveyed it will be is necessary to sample them. If it is necessary to sample program facilities because covering all such facilities is infeasible, the guidelines for Scenario 1 should be followed. In this event, the sample design would be a two-stage cluster design.

Sampling "comparison" facilities

As described earlier in this section, there are two primary options for selecting "comparison" facilities. If matching is to be used to identify appropriate comparison sites, the matching process constitutes the sample selection process, and no further sampling will be needed.

If comparison facilities are to be chosen by taking a sample of facilities in a comparison area, facilities in the comparison area should be chosen using the two-stage cluster procedure described above in connection with Scenario 1, with sample facilities chosen using systematic sampling with probability proportional to size (PPS). In some instances, however, it may be possible to include all facilities in the comparison area in the survey(s).

Estimation

Weighting

Whether or not the survey data will need to be weighted during analysis will depend upon the sample design used. The weighting procedures for intervention facilities will correspond to those either for Scenario 1 or 2.

If all intervention facilities are included in the survey and each facility is visited for the same length of time (as in Scenario 2), all service transactions observed and clients interviewed will have the same overall probability of selection, and the data will not need to be weighted prior to analysis. If sampling of facilities is necessary, the data will not be self-weighting, and it will be necessary to weight the data as in Scenario 1. The reader is referred to the weighting procedures for Scenario 1.

If comparison facilities are chosen via matching and all facilities are visited for the same length of time, the resulting data may be treated as self-weighting as in Scenario 2. If sampling of facilities is necessary, the data will not be self-weighting, and it will be necessary to weight the data as in Scenario 1.

Note that it is possible that intervention and comparison facilities will receive differential treatment with regard to weighting if they were chosen using different sampling schemes. This situation may be handled by assigning weights calculated as described in connection with Scenario 1 to service observations and client exit interviews chosen with unequal probabilities of selection, and weights of 1.0 to observations chosen with equal probability.

Variance estimation

As all service observations and client exit interviews are expected to be chosen using some form of cluster sampling, it will be necessary to take into account design effects in the calculation of standard errors of survey estimates. See Scenario 1 for a list of computer software packages that correctly handle variance estimation for cluster sample designs.

Sampling plan for subsequent survey rounds

In principle, the sampling strategy chosen for subsequent survey rounds will depend upon how the sampling was done for the initial survey round. However, as a primary measurement objective in this scenario is to measure the impact of service quality improvement interventions, a case may be made for retaining the same sample of intervention and comparison facilities in subsequent survey rounds. The major advantage of this strategy is that it increases the precision of estimates of changes on key indicators over time, thus increasing the chances that "real" differential improvements in service quality at intervention facilities can be detected.

However, if monitoring of comparison sites is to be carried out over a number of survey rounds, it may be difficult to maintain cooperation from such sites. In this case, the site rotation strategy outlined earlier in connection with Scenario 1 is recommended.

Scenario 4: A low-prevalence country would like to monitor the quality of services under any of the Scenarios 1-3

Measurement objectives

Scenario 4 concerns countries where the level of contraceptive prevalence is low, implying low client volume at facilities offering family planning services. The major issue to be addressed in this scenario is that because of low client volume, data collection teams will have to remain at facilities for considerable periods of time in order to obtain sufficient numbers of service observations and client exit interviews under any of the Scenarios 1-3.

To illustrate, suppose the desire was to obtain 400 service observations and client exit interviews in a setting where the ten program facilities see an average of only .5 family planning clients per day. In this setting, field teams would have to remain at each facility for a total of eight days in order to reach the target sample size. Aside from resulting in relatively high data collection costs, having observers at program facilities for extended periods of time may have a greater influence on the manner in which service providers deal with clients than with more limited periods of observation, resulting in higher bias.

If one is willing to accept this risk of higher "observation" bias, the sampling guidelines for any of the above scenarios could be applied to Scenario 4. However, either a larger sample of facilities, longer observation periods per facility, or both will be needed in order to obtain sufficient numbers of service quality observations.

An alternative approach in such settings would be to substitute other data collection methods for observations of service transactions and client exit interviews.[7] Specifically,

1. Mystery client visits to health facilities could be used instead of observations of service transactions to obtain data on actual service delivery performance, and
2. Interviews with clients in their homes shortly after receiving services could be substituted for interviews undertaken as they leave facilities.

Sampling guidelines for the use of these alternative data collection approaches are described in this section.

Sampling frame requirements

Mystery client visits

For the purposes of undertaking mystery client visits, what is needed in the way of a sampling frame will depend upon whether or not it is possible to include all program facilities on the survey:

- If it is necessary to sample facilities, a list of facilities with a count of numbers of family planning clients during a recent period (e.g., the last 6 or 12 months) will be needed.
- If all facilities can be included in the survey, a list of program facilities will suffice.

Client home interviews

Undertaking client home visits may require two types of sampling frames:

- A list of facilities, along with a count of numbers of family planning clients during a recent period, if the number of facilities in the program is too large to cover all facilities in the survey, and
- A list of clients during a recent period (e.g., the last 3 months[8]) for each sample facility. These data may be obtained from facility service registers, logs, or similar record systems in which the names of family planning clients are systematically recorded. [Addresses and/or other information that could be used to locate clients will eventually be needed, but not until the facilities and clients to be included in the sample have been determined. Most if not all programs and facilities include at least rudimentary information on place of residence on client service records that could be used to these purposes.]

The length of the reference period for the list of clients will depend upon the volume of clients at facilities. The key is that the reference period be long enough to provide the required number of clients to be visited at their homes, but is short enough to ensure that clients will be able to recall what transpired during visits to facilities.

[7] Note: Because different clients would be used for the exit interviews and the observation, it is not possible to link the results of these two instruments in this case.

[8] Note: Interviewing clients whose last visit to the clinic was greater than three months ago will result in greater recall bias. Users should be aware of the trade-off between quantity and quality of data; a greater quantity of data is likely to be at the expense of quality.

For example, if it were desired to visit an average of 10 clients per facility and facilities saw an average of 10 clients per month, then only clients in the past month would be needed. Where client volume is lower, longer reference periods would be required. While there is no hard and fast rule as to maximum length of the reference period, recall periods of 12 months should be viewed as a maximum, and shorter recall periods of 3-6 months are much preferred.

Sample size requirements

Number of visits/home interviews needed

- Mystery client visits

In principal, the number of mystery client visits to be undertaken would be determined in the same manner as described for the relevant scenario from Scenarios 1-3 above. However, because the appearance of a number of "new clients" at facilities can raise suspicions among facility staff (especially in rural areas and/or where client volume is low – see below), there are limits to how many mystery clients visits can be undertaken per facility. As a practical matter, 2-3 mystery clients per facility should not pose a problem. More mystery clients visits might be possible at facilities with higher client volumes, but even here there is a practical limit of 5-6 per facility.

Prior experience with mystery client studies suggests that "new clients" in rural areas, where client volume is often low and service providers often personally know most or all clients residing in their facility's catchment area, tend to be "detected" by facility staff. Thus, in some settings it may be possible to use the mystery client strategy only in urban areas.

- Client home interviews

The number of clients to be chosen for home visits is determined in the same manner as described for the relevant Scenario above.

Number of facilities and number of visits/client home interviews per facility

- Mystery client visits

Because of the limitations on the number of mystery client visits per facility that are feasible in most settings, 2-3 visits per low-volume facility and 5-6 per high volume facility are about the best that should be expected. In Scenario 1, the number of visits could be increased by including larger numbers of facilities in the sample. However, in programs with a limited number of facilities (Scenario 2), even taking all facilities may not result in a sufficient number of visits to be able to measure changes in service quality accurately.

Because of these limitations, it may not be possible in many settings to reach the number of visits needed to accurately measure changes in service quality. Generally, it should be anticipated that the mystery client approach will permit the accurate measurement of only large changes in service quality indicators.

- Client home interviews

The number of facilities and number of clients to be chosen for home visits per facility will depend upon (1) the number of client interviews needed to be able to accurately measure changes in service quality indicators (i.e., the required sample size) and (2) the number of facilities to be covered in the survey:

If it is necessary to sample facilities, it is recommended that no more than 20 clients be chosen per facility. The reasons for this are twofold: (1) taking larger numbers of clients per facility may result in too few facilities being chosen, resulting in large design effects and inaccurate estimates of changes in service quality indicators, and (2) taking larger numbers of clients per facility may result in choosing clients whose last service visit to the facility was some time in the past (e.g., 12 months or more), resulting in increased recall error.

As an example, suppose that n=600 client home visits are needed. One option would be to choose n=20 clients per facility, meaning that a sample of 30 facilities would be needed. However, if this plan resulted in a large number of clients being chosen for home interviews whose last visits were more than 12 months ago, a better strategy would be to reduce the per-facility sample to n=15 and choose a sample of 40 facilities (60 facilities with 10 clients per facility would be even better).

If all facilities are to be included in the survey, the required number of client home visits per facility would be determined by dividing the target sample size by the number of program facilities. For example, if the target sample size were n=600 client home visits and there were 10 facilities in the program, n=60 client home visits would be required per facility. It will be noted that such large numbers of clients per facility will be both inefficient statistically and may result in large numbers of clients whose last visit to the facility was some time in the past to be chosen for the sample. On statistical grounds, 40-45 should be viewed as an upper bound for sample sizes per facility. The implications of samples of various sizes for the length of time of last client visits will have to be judged on a case-by-case basis.

Sample design

Mystery client visits

The sample selection procedures for undertaking mystery client interviews will depend upon whether all such facilities can be included in the survey (as in Scenario 1), or it will be necessary to sample facilities (as in Scenario 2).

- If it is necessary to sample program facilities (because covering all such facilities is infeasible), the guidelines for choosing facilities in Scenario 1 should be followed. A predetermined, constant number of mystery client interviews should then be attempted at each sample facility. This two-stage cluster design will result in a self-weighting sample.
- If resources will permit all program facilities to be included in the survey, a one-stage cluster design is appropriate, and no first-stage sampling is required. A predetermined, constant number of mystery client visits would be made to each program facility. This also will result in self-weighting sample.

Client home visits

The sample selection procedures for client home visits will also depend upon whether or not all such facilities can be included in the survey.

- If it is necessary to sample program facilities, the guidelines for choosing facilities in Scenario 1 should be followed. Systematic-random selection of facilities with probability-proportional-to-size (i.e., client volume) is recommended—see Table 5. A predetermined number of clients per facility would then be chosen at the second stage of sample selection to be visited at home. Ideally, this would be done also using a systematic-random selection procedure. This could be done, for example, by taking every 3rd, 5th, 7th (etc.) client from a facility register or client file. As noted earlier, however, it is recommended that only clients who had visited the facility recently (e.g., in the past 6 months or so) be eligible for inclusion in the survey.

Note that if a constant number of clients were to be chosen from each sample facility, each client interviewed at home would have the same overall probability of selection, and it would thus be unnecessary to weight the data.

- If resources will permit all program facilities to be included in the survey, a one-stage cluster design is appropriate, and no first-stage sampling is required. If a constant number of clients were to be chosen from each program facility, this would result in a self-weighting sample, and no weighting of the data will be required during analysis.

Estimation

Weighting

The sample designs recommended above result in self-weighted samples, which means that the survey data will not need to be weighted during analysis. The key to obtaining self-weighted samples is that the same number of mystery clients be made to each facility and the same number of clients be chosen from each facility for home visits.

Variance estimation

As all service observations and client exit interviews are expected to be chosen using some form of cluster sampling, it will be necessary to take into account design effects in the calculation of standard errors of survey estimates. See Scenario 1 for a list of computer software packages that correctly handle variance estimation for cluster sample designs.

Sampling plan for subsequent survey rounds

The issues concerning sampling strategy chosen for subsequent survey rounds under this scenario are the same as for the relevant scenario from among Scenarios 1-3. The reader is referred to the discussion under the appropriate Scenario.

Conducting the Training

The breadth and duration of training will be largely dependent upon the objectives and the resources available for the study. It is recommended that training take between five and seven days.

Figure 3.1. Illustrative Training Schedule.[9]

DAY	TRAINING ACTIVITY
1	• Introductions • Background of QIQ • Methodological issues: reliability, validity, data collection issues • Review facility audit and guidelines
2	• Review tips for observers • Review observation guide and guidelines • Review tips for interviewers • Review client exit interview and guidelines • Discuss issues arising from instrument reviews (e.g., items that need to be modified or added to adapt to local circumstances)
3	• Review terminology • Discuss ethical issues relevant to the administration of each instrument • Role play • Discuss role play
4	• Field test instruments in clinic facilities[14]
5	• Discuss field test experience as a group[15] • Discuss field test experience by area of specialization • Further review each instrument and determine if any further modifications need to be made
6	• Discuss role of supervisor and review supervisor's guidelines • Break into research teams and review study logistics • Wrap up

Training is an extremely important component of conducting the study; the extra time and effort spent in this activity will increase the validity and reliability of the results, and allow people to understand what is expected of them as they conduct the study.

The first part of training should focus on familiarizing participants with the objectives of the study and the QIQ methodology. A review of the instruments and guidelines should include: defining terms, reviewing the meaning of questions and how to record answers, discussing protocol, and adapting the methodology to local conditions as necessary.

[9] Note: This illustrative training schedule is drawn from: The Situation Analysis Approach to Assessing Family Planning and Reproductive Health: A Handbook (Miller et al., 1997) and from experience of those countries involved in the QIQ field test.

[10] Note: The field test should be conducted in clinic facilities that will not be involved in the study.

[11] In an effort to increase inter-rater reliability, all of the observers involved in the study should observe the same session, (either simulated/role-play or videotaped), complete the observation form, and then discuss differences in how sessions were rated.

As the training progresses, participants should role-play and eventually field test the instruments to further increase their familiarity with the instruments and to continue to refine them. Prior to the field test, however, a few methodological issues need to be addressed:

Inter-rater reliability: Observers should be trained so that they mark items on the observation guide in a similar manner. One way to increase inter-rater reliability is for observers to watch the same interaction between the client and the provider. This can be a role-play/simulation or a videotaped interaction. Afterwards, observers can discuss how they mark different items on the observation and why there may have been differences in what was observed. Through this process, observers can achieve consensus on how to mark the observation guide.

Courtesy bias: It is likely that the client exit interviews will reveal a better picture of quality than what actually exists. Clients may feel inclined to say complementary things about the services received because they may fear that it will threaten their continued service at the clinic. In order to minimize this bias, interviewers should be trained to assure clients that they should feel free to express their opinions honestly without the threat of losing services at the facility.

Ethical issues should also be addressed at this stage of the training. Some ethical issues include obtaining informed consent from both the providers and the clients, and determining when it is necessary to intervene during the observation of the client-provider interaction.

A last component of the training is a review of the logistics of the study (see Supervisor's Guidelines). Important components of this section of the training include: describing how to select participants for the study; how to link the observation to the client exit interview; and how transport, accommodation, and per diem will be arranged for the research team.

Field Guide for Supervisors[12]

Overview

The number of research teams and supervisors used in a study depends on the number and accessibility of clinic facilities, the objective selected and the resources available. Typically, a research team will consist of at least three people.[13]

The person observing the client-provider interaction should have clinical training (e.g., doctor, nurse, midwife, etc.), and the client exit interviews should be performed by a social scientist with interview experience. Since the facility audit requires the researcher to examine medical equipment and to interview the manager of the facility, the person administering this instrument should have a clinical background and possess interviewing skills. Each team will have a supervisor who also may be one of

[12] Material in this section draws heavily on ideas from *The Situation Analysis Approach to Assessing Family Planning and Reproductive Health Services: A Handbook* (Miller et al., 1997), but includes suggestions pertinent to this particular data collection exercise.

[13] Note: The number of team members may vary depending on the volume of the clinics included in the sample; more interviewers and/or observers may be required in high volume clinics than in low volume clinics.

the persons involved in the data collection. In addition, the supervisor is responsible for overseeing the day-to-day operations outlined below. Other team members are primarily in charge of administering the data collection instruments and assisting the supervisor with the daily responsibilities of the study.

Roles and Responsibilities of Supervisor

Supervisors have a number of responsibilities concerning the fieldwork. Supervisors should be prepared to assist at all times with regard to field operations. High morale among supervisors is a very important factor in the successful execution of the fieldwork. This means that the team members have to be sensitive to each other's needs and points of view. Where difficulties arise, the supervisor may be responsible for facilitating the problem-solving process. Above all, remember that each team member has different resources and abilities, and these should be tapped to make the field experience successful. Some issues that need attention while in the field are discussed below:

Obtain permission from local authorities

Permission to visit clinic facilities should be obtained from local authorities. The clinic supervisor will be furnished with an official letter of introduction. When the team arrives at a clinic in the morning, the supervisor will arrange a meeting with the clinic supervisor to introduce the study and the field team. He or she is responsible for explaining the goal of the study to the supervisor and for requesting his or her permission to proceed with the study. It is important to reassure clinic staff that the interviews and observations are being done as part of a scientifically designed, large-scale study and the results will not be used to critique their work as individuals.

Arrange transportation

The supervisor has to make sure that transportation is available and ready every day to take the interviewers to the field. The driver, who becomes part of the field team, has to receive clear instructions on where and when to go. Public transportation may be used as an alternative, but this is usually not satisfactory except in some urban areas.

Verify basic clinic identification

The supervisor has been provided with a listing of the clinics the team is to visit during the fieldwork. During the first meeting with the clinic supervisor, the supervisor should verify that the team is indeed at the correct clinic. Obtain the correct name and spelling for the clinic. Verify the region, level and type of facility and locality as well. Once this information is verified, the supervisor will double-check with the interviewers and observers to make sure that they all have the correct information to complete the cover page of the questionnaires.

Link observation and client exit interview instruments

The goal of this survey is to interview all the clients who have been observed by a team member during the examination and counseling phase of his/her visit. In order to do this, the team leader will have a series of colored cards with numbers on them. Each patient who goes in for counseling and an exam is given a card, starting with the card numbered "1." When this patient leaves the examination

room, s/he is instructed to show his/her number to the observer in the exam room and then give it to the person doing the exit interviews outside. This allows the interviewer to keep track of the clients coming out of the examination room. In the event that the client sees two providers during the course of his/her visit (one for the exam and another for the counseling) s/he is to keep the colored card with him/her. S/he will still need to present it to the person performing the exit interview. The team leader and exit interviewer will keep track of the colored cards as a means of knowing how many clients were observed and making sure they were also interviewed on their way out of the clinic. Note: The number on the colored card will be the "client number" on both the observation guide and the client exit interview. It is extremely important that a client has the same number on both instruments so that they may be correctly linked in the analysis.

Check on completion of instruments

On a daily basis, the supervisor checks the entries to the data collection instruments to verify the consistency and accuracy of the data collected. This will include making sure that observation and client exit interview numbers are correctly linked, all items are filled out, and skip patterns are correctly followed. If the reviews are done as a group, it provides a training experience for the team members. This will be particularly important during the first few days of the study.

For all of the instruments, some information on the cover page can be filled in before a visit to the facility is made. This is encouraged since it saves time and allows for prior planning to make sure that all details are consistent.

To maintain a sufficient supply of instruments, the supervisor has to keep in contact with the Country Coordinator. Normally, the date for a field visit by the Country Coordinator will be arranged during the training session.

Secure questionnaires

After each observation or interview, the team member will turn in his or her questionnaires to be double-checked. The supervisor is responsible for verifying the following points:

- The coversheet contains the correct identification information;
- All questions have been answered to the extent possible;
- The answers are clear and legible;
- Each client who was observed was also interviewed after the examination (or to make a note if the client refused either the observation or the interview).

If there are noticeable problems on the questionnaires (blank questions, illegible answers), try to correct these problems while the team is still at the clinic. It is much more difficult to correct the questionnaires after you have left the site.

Once the completed questionnaires are verified, the supervisor arranges them in logical order according to type and date of visit to the facility.

Provide technical support for the team

The team leader must be familiar with the objectives and methodology of the study. Issues may arise during the fieldwork that will need to be resolved in a way that is consistent with the overall goals of the study. It is a good idea to meet with the team briefly at the end of each day. During these meetings, the team can raise issues that developed during the day and arrive at an agreement as to how to handle them.

Keep in contact with the head office

If the team experiences unusual difficulties or is in doubt about certain issues, the head office or study coordinator should be contacted immediately.

Keep a daily summary record

At the end of each day, the supervisor reviews with the other team members the activities of the day and then writes a brief report (usually 1/2 to 1 page). The report may include events at the clinic facility that made the data collection process unusual—perhaps too easy or too difficult. The report is a summary of the experiences of the team and is valuable information for interpreting the research results.

Substitute interviewers (if necessary)

There may be times when someone on the team is ill or otherwise unable to do his/her job. If appropriate, the team leader may substitute for that person as an interviewer or in conducting the facility inventory. However, in the case of observation, the sex of the observer should continue to be matched with the client's sex (e.g. a male team leader should NOT substitute for the female observer).

Logistics

The team supervisor is responsible for managing the overall functioning of the team. This includes planning the fieldwork, contacting the clinics to be visited, and supervising the activities of the team. The following are some guidelines to help with logistics.

Plan the overall fieldwork

The team will be given a list of facilities to be visited. The supervisor should work with the team (including the driver) to plot the most effective way to visit each of these facilities in the time allotted for fieldwork. Some of the facilities might be in rural areas at quite a distance from urban centers. The time needed to reach the facility and return to an urban area for the night need to be calculated into the overall plan. In urban areas, the team might be able to visit more than one facility during a day, however this probably won't be the case in rural areas. Don't try to accomplish more than is possible in one day as this may jeopardize the quality of the fieldwork. In addition, the supervisor will need to identify where the team will spend the night and make sure arrangements have been made for lodging the team.

Contact facilities

The technical coordinator and others at the central level have the primary responsibility for obtaining permission for the study and contacting the facilities you will be visiting. However, the team supervisor should always contact the facility in advance to advise them that the team will be arriving

and will need their assistance. Often this can be accomplished by a quick phone call to the clinic. However, if the team leader is not able to contact the clinic in advance, the team should try to allow a little more time for introductions and explanations when they first arrive at the site.

Maintain materials and supplies

The team supervisor is responsible for the materials necessary to complete the job. Before embarking on the fieldwork, the leader should double-check the materials to make sure the team has sufficient copies of the questionnaires, interviewers' guides, pens and clipboards, and whatever other supplies are necessary. Take several extra copies of the questionnaires in case you should need them. Check with the driver to make sure the vehicle has been maintained and that he has coupons or money to purchase fuel for the vehicle while the team is in the field.

The Research Team and a Typical Day

Prior to arriving at the clinic, perhaps during the previous evening, the team members should make sure that the "standard codes" for identifying the type and location of the clinic facility to be visited have been agreed upon, and possibly entered in advance on the cover of each instrument to be used. The codes for the type of facility, type of sector and type of locality should be discussed with the person in charge of the facility and should be consistent for every instrument used at that facility. Moreover, the codes for each staff member and client must be carefully recorded for each interview and observation and must match across instruments. The supervisor should assign these codes for staff and clients after arriving at the facility. These "linking" variables are extremely important in the data analysis, so these codes should always be checked thoroughly by the supervisor.

The team should always arrive at the facility before the official opening time. This is necessary in order for them to observe what happens when the facility opens and, of course, if it opens on time.

The team member with clinical training typically begins observing the interaction between family planning clients and the provider(s) at the start of the day. Later, this person can also help one of the other team members to complete the inventory of equipment. The second person on the team is usually responsible for client exit interviews. He or she may also help with collecting information on clinic records, reporting, and service statistics.
At the end of the day, the supervisor should review with the other team members the visit to the facility. As mentioned above, the supervisor should then write a brief (1/2 to 1 page) report of the visit, noting any unusual circumstances or occurrences that are important but that will not be apparent from the data collection instruments.

In addition, the supervisor must also review every instrument to ensure that all responses are correctly recorded. This step is sometimes difficult to complete at the end of a long day, but its importance cannot be overemphasized. If the questionnaires are missing information, the quality of the data is highly compromised, and the results will be less informative and sometimes even unusable. Thus, the cost of missing data is high, and it should be strictly avoided. The check for missing data at the end of the day in the field may be tiring, but it represents the last opportunity to complete any information that is missing.

Module 3:
Facility Audit & Manager Survey

- Tool
- Guidelines

Overview

The facility audit is used to determine the readiness of a facility to deliver services. It collects information on equipment and commodities, condition of the facility, IEC materials, supervision, information and management systems, and protocols and guidelines.

Identification Number: ☐☐ Region ☐☐ District ☐☐ Facility

Facility Audit and Manager Survey

Instructions: Complete this inventory using observation and discussion with the person in charge of family planning services. Verify the existence of functional equipment and supplies and the condition of the facility through observation. If you cannot observe the equipment, supplies or conditions, then indicate this in the margins.

Note: The respondent should be the manager of the facility.

BACKGROUND CHARACTERISTICS

01. Health Facility (Name & Number): _____ ☐☐

02. District (Name & Number): _____ ☐☐

03. Region (Name & Number): _____ ☐☐

04. Date of interview: ☐☐ Day ☐☐ Month ☐☐ Year

05 Type of Facility Where Observation Took Place

☐1. Referral Hospital
☐2. Hospital
☐3. FP Clinic
☐4. Health Center
☐5. Health Post
☐6. Mobile Health Clinic
☐7. Clinics in non-permanent facilities (schools, rotating rural health outposts, etc.)
☐8. Other _____

06. Type of Sector

- ☐ 1. Government/Ministry of Health
- ☐ 2. Government/other
- ☐ 3. FP Association (IPPF affiliate)
- ☐ 4. Other NGOs
- ☐ 5. Missionary
- ☐ 6. Private
- ☐ 7. Other

07. Locality of Facility

- ☐ 1. Rural
- ☐ 2. Urban
- ☐ 3. Peri-urban

Name of Interviewer:_____

Signature of Team Leader_____

Note: Use military time to complete the following.

1a. What time is the clinic scheduled to open? ☐☐:☐☐
(OBSERVE OR ASK)

Could not be determined ☐

1b. What time did the clinic actually open? ☐☐:☐☐
(OBSERVE)

Could not be determined ☐

1c. What time (at or after the clinic opened) did the first client arrive? ☐☐:☐☐
(*OBSERVE)*

Could not be determined ☐

1d. What time was the first client seen? ☐☐:☐☐
(OBSERVE)

Could not be determined ☐

Section I Equipment and Commodities Inventory

2. Which of the following contraceptive methods are provided at this facility?

Record below which contraceptive methods are usually provided at this facility. If the method is usually provided, determine if it is available today. If it is available at the facility today, count the approximate number of non-expired units of each method available in either the facility or the storeroom. For each method provided, ask whether there has been a stockout in the last six months.

(OBSERVE AND ASK)

Type of Contraceptive	Usually Provides Method	Available Today	Available (Approximate # of Units)	Stockout Last 6 Months
A. COMBINED PILLS	Yes No	Yes No		Yes No
B. PROGESTERONE-ONLY PILLS	Yes No	Yes No		Yes No
C. IUD	Yes No	Yes No		Yes No
D. COMBINED INJECTABLES	Yes No	Yes No		Yes No
E. PROGESTERONE-ONLY INJECTABLES	Yes No	Yes No		Yes No
F. MALE CONDOMS	Yes No	Yes No		Yes No
G. FEMALE CONDOMS	Yes No	Yes No		Yes No
H. SPERMICIDE	Yes No	Yes No		Yes No
I. DIAPHRAGM	Yes No	Yes No		Yes No
J. EMERGENCY CONTRACEPTION	Yes No	Yes No		Yes No
K. CYCLE BEADS	Yes No	Yes No		Yes No
H. OTHER_____ (specify)	Yes No	Yes No		Yes No

3. When you run out of contraceptives, how long does it take to replace them?

(ASK)

- ☐ 1. One week or less
- ☐ 2. One month or less
- ☐ 3. Six months or less
- ☐ 4. Other_____
- ☐ 8. Don't know

4. Which services are offered at this facility?

For each service, first record if it is provided, and then record whether the service has been available at <u>all</u> times in the last six months. If the service has NOT been available at all times in the last six months, mark the reason why it was <u>last</u> not available and record the length of time it was not available.

(OBSERVE AND ASK)

Type of Service	Provided	Available at <u>all</u> times in last 6 months	If no, reason not available last time
A. FEMALE STERILIZATION	Yes No	Yes No	☐1. Supplies not available ☐2. Equipment not available ☐3. Trained staff not available ☐4. Other _____
B. VASECTOMY	Yes No	Yes No	☐1. Supplies not available ☐2. Equipment not available ☐3. Trained staff not available ☐4. Other _____
C. IMPLANT	Yes No	Yes No	☐1. Supplies not available ☐2. Equipment not available ☐3. Trained staff not available ☐4. Other_____
D. NATURAL FAMILY PLANNING	Yes No		
E. OTHER **(specify)_____**	Yes No	Yes No	☐1. Supplies not available ☐2. Equipment not available ☐3. Trained staff not available ☐4. Other _____

5. When you are unable to perform family planning services, how long does it take for them to resume?

(ASK)

☐ 1. One week or less
☐ 2. One month or less
☐ 3. Six months or less
☐ 4. Other_____
☐ 8. Don't know

6. Which of the following types of equipment are available <u>and</u> in working order?

Ask to see each type of equipment. If there is at least one available in working order, mark the corresponding box on the table. (Note: many items will be found in "minilap kits," "IUD kits," or "no-scalpel vasectomy kits.")

(OBSERVE AND ASK)

EQUIPMENT AND SUPPLIES	MARK IF AT LEAST ONE IS AVAILABLE
1. Flashlight	
2. Working lamp	
3. Scale	
4. Blood pressure gauge	
5. Thermometer	
6. Stethoscope	
7. Scissors	
8. Sterile needles and syringes	
9. Specula	
10. Tenacula	
11. Uterine sound	
12. Alligator forceps	
13. Sponge holding forceps	
14. Artery forceps	
15. Dressing forceps	
16. Tissue forceps	
17. Mosquito forceps	
18. Intestinal forceps	
19. Babcock forceps	
20. NSV ringed forceps	
21. Scalpels	
22. Sutures	
23. Needle holder	
24. Retractor	
25. Tubal hook	
26. Sharp trocars	
27. Sterilizers	
28. Iodine	
29. Xylocaine or lignocaine	

EQUIPMENT AND SUPPLIES	MARK IF AT LEAST ONE IS AVAILABLE
30. Antiseptic	
31. Chlorine solution	
32. Sterile gloves	
33. Disposal containers for contaminated waste/supplies	
34. Sharps containers for used sharps	
35. Plastic buckets or containers for decontamination	
36. Clean instrument containers	
37. Instrument trays	
38. Swab containers with sterile swabs or sterile gauze	
39. Examination couch or table	
40. Examination table capable of trendelenburg	
41. Operation theater	
42. Recovery room	
43. Procedure area for IUD, injectables or implants	

7. Are facilities for storing contraceptives adequate in the following respect: ***(OBSERVE)***

A. Products are protected from the rain.

☐ 1. Yes
☐ 2. No

B. Products are off the floor and on shelves.

☐ 1. Yes
☐ 2. No

Section II Conditions of Facility

8. Verify if there is a client waiting area with seating that is sheltered from sun and rain at the clinic.

Note: The waiting area must have some form of seating.

(OBSERVE)

- ☐ 1. Yes
  - ☐ A. Shelter
  - ☐ B. Seating
  - ☐ C. Both
- ☐ 2. No

9. Ask the respondent: "May I see where family planning clients are examined?"

Choose the response that best describes where examinations take place.

(OBSERVE AND ASK)

- ☐ 1. Separate room, no ability to see into the room from outside
- ☐ 2. Behind a curtain
- ☐ 3. Other area that ensures privacy
  *Explain*_____
- ☐ 4. No privacy

10a. What is the source of the water used in the facility today?

(OBSERVE AND ASK)

- ☐ 1. Piped
- ☐ 2. Water from protected well/borehole
- ☐ 3. Water from unprotected well/borehole
- ☐ 4. Surface water
- ☐ 5. Other _____
  (specify)

10b. Is this source located within the compound?

(OBSERVE AND ASK)

- ☐ 1. Yes
- ☐ 2. No

Section III IEC Materials and Activities

11. Is there a sign on the street or on the exterior of the building announcing that family planning services are available?
(***OBSERVE)***

☐ 1. Yes
☐ 2. No

12. Which family planning IEC materials are available?
(OBSERVE OR ASK)

Type Of Material	Yes	No
A. Posters		
B. Flip Chart		
C. Brochure/Pamphlet (at least 10)		
D. Information Sheet (at least 10)		
E. Job Aids		
F. Counseling cards		
G. Other (specify)_____		

Section IV Supervision

13. What was the date of the last "outside" supervisory visit which included a review of family planning services?
(OBSERVE OR ASK)

☐☐/☐☐
month year

Section V Protocols and Guidelines

14. Please show me the most recent version of written guidelines and protocols for delivering family planning services.

Record "yes" if at least one set of written guidelines is available.

(OBSERVE AND ASK)

☐ 1. Available and observed _____
(record date of version)

☐ 2. Available, but not observed
☐ 3. Not available
☐ 8. Don't know

15. Please show me where all of the client records are kept.

Record "yes" if client records are kept in a secure area.

(OBSERVE AND ASK)

☐ 1. Yes
☐ 2. No
☐ 8. Don't know

Section VI Use of Information in Clinic Management

16. What methods do you have for determining client opinions?
Read options and mark all that apply.
(ASK)

☐ 1. Yes (mark the specific method below)
- ☐ A. Client suggestion box
- ☐ B. Provider asks client
- ☐ C. Other staff asks client
- ☐ D. Other _____

☐ 2. No method available ***(go to #19)***

17. In the past quarter (3 months), have any changes been made in the program based on feedback from clients?
(ASK)

☐ 1. Yes
☐ 2. No ***(Go to question #19)***
☐ 8. Don't know ***(Go to question #19)***

18. What changes have taken place?
(ASK)

EXPLAIN_____
_____
_____

19. What methods do you have for determining provider opinions?
Read options and mark all that apply.
(ASK)

☐ 1. Yes (mark the specific method below)
- ☐ A. Staff suggestion box
- ☐ B. Staff meetings
- ☐ C. Internal clinic evaluations
- ☐ D. Other _____

☐ 2. No method available ***(go to #22)***

20. In the past quarter (3 months), have any changes been made as a result of provider opinions.
(ASK)

☐ 1. Yes
☐ 2. No ***(Go to question #22)***
☐ 8. Don't know ***(Go to question #22)***

21. What changes have taken place?
(ASK)

EXPLAIN_____
_____
_____

Section VII Service Statistics

22. How many clients received family planning services in the last 4 completed quarters (12 months)?
(OBSERVE OR ASK)

A. TOTAL NEW FAMILY PLANNING ACCEPTORS	B. TOTAL FP VISITS

23. Overall, how many client visits for MCH, FP, and general exams were recorded at this clinic in the last 4 completed quarters (12 months)?
(OBSERVE OR ASK)

_____#

24. How many clinical service providers are usually available to see family planning clients?
(ASK)

_____#

Facility Audit and Manager Survey Guidelines[14]

Overview

This instrument may be filled out all at one time or over the course of the day-long visit to the clinic. It should be started soon after arrival. The person collecting the data needs to be someone with a medical background, such as a physician, nurse, or medical or nursing student. The process of conducting the inventory requires making observations and asking questions of the staff in charge of FP services at the facility. Some items on the instrument require observation and some items require directly interviewing the facility manager. Although some items on the facility audit are questions to the manager, it is important to verify through observation the information that she/he gives whenever possible. In most cases, items should first be observed and then further clarified by asking the facility manager. The guidelines specify whether one is expected to observe or ask the program manager about a particular item. Instructions for the person conducting the "Facility Audit and Manager Survey" appear *in italics*. These instructions are not to be read to the respondent.

NOTE: Since the staff in charge of FP services will be busy with observations and client exit interviews during this same survey, members of the field research team should coordinate times for each instrument and be sensitive not to overwhelm the clinic staff.

Cover page: (explanation)

Identification Number

Country Specific. The number of digits for the identification number is country specific. Some countries may not have both regions and districts. This number uniquely identifies each facility. The codes should be entered in the following sequence: region, district, and facility. These numbers may be assigned specifically for this study or an existing ID number may be used.

01. Health Facility (Name and Number)
02. District (Name and Number)
03. Region (Name and Number)

It is important that the correct numbers and names are recorded for the observation identification, health facility, district, region, and provider. The supervisor or the team leader should make sure that the correct numbers are recorded here.

04. Date of Interview (with program manager)

Record today's date here. Record the day first, then the month, followed by the year. For example, if the date is April 14, 2001 write: | 1 | 4 | | 0 | 4 | | 0 | 1 | .

05. Type of Facility where the Observation Took Place

The type of facility refers to the services offered. The types will vary by country, but should reflect the actual structure of health facilities available in the country.

[14] The instructions for the interview teams were drawn largely from The Situation Analysis Approach to Assessing Family Planning and Reproductive Health Services: A Handbook (Miller et al., 1997).

06. Type of Sector

Sector type describes the sponsoring agency for the facility. The types will vary by country. If there is any question about the type (e.g., multiple sources of financial staffing or commodity support) refer the selection to a supervisor.

07. Locality of Facility

Country specific. Mark the appropriate locality in which the facility operates. The locality is usually determined administratively. It may be necessary to ask or check with local officials. Urban clinics can appear to be in a rural area and be serving a rural population. Some countries may only denote "rural" and "urban" areas. Adapt the locality to reflect the situation in your country.

1a. What time is the clinic scheduled to open?

(OBSERVE OR ASK)

The time that the clinic is scheduled to open may be determined by observing posted clinic times or by asking the manager of the clinic (or other personnel) what time the clinic is supposed to open. Official opening times should be available from the Ministry of Health or the head office of the organization that runs the clinic. Record both the hour and minutes using a 24-hour clock (military time). For example, if the first patient arrived at 8:00 AM record 08:00. If the first patient arrived at 1:00 PM, record 13:00.

1b. What time did the clinic actually open?

(OBSERVE)

This question will determine if the facility is actually open and providing services at the official opening time. It is necessary to arrive at the facility before it is scheduled to open to determine if it did indeed open on time. As above, record both the hour and minutes using a 24-hour clock (military time).

1c. What time (at or after the clinic opened) did the first client arrive?

(OBSERVE)

Record the actual time that the first client (for family planning or any other services) arrived (at or after the clinic is scheduled to open). As above, record both the hour and minutes using a 24-hour clock (military time).

1d. What time was the first client seen?

(OBSERVE)

Record the actual time that the first patient was seen by a provider (i.e., doctor or nurse, for any service). As above, record both the hour and minutes using a 24-hour clock (military time).

Section I Equipment and Commodities Inventory

2. Which of the following contraceptive methods are provided at this facility?

Record below which contraceptive methods are usually provided at this facility. If the method is usually provided, determine if it is available today. If it is available today, count the approximate number of non-expired units of each method available either in the facility or the storeroom. For each method provided, ask whether there has been a stockout in the last six months.

A. Type of contraceptive
B. Usually provides method
C. Available today
D. Available (approximate number of units)
E. Stockout in last 6 months

(OBSERVE AND ASK)

The purpose of these questions is to find out if the facility provides a particular contraceptive method and, if so, how reliable are its contraceptive stocks. The stocks are particularly important because if there are no commodities, a facility simply cannot provide a method, even it if is otherwise ready to do so.

Ask the staff in charge of the FP services which methods are usually provided at the facility. If the staff mention names that are not included on the form, write them in the "other" category and continue as usual. Go to the stock room or cabinet and count the approximate amount of the contraceptive supplies. By "approximate number," we mean that the observer should count the number of full boxes and multiply by the volume in each box; then add the number of items from partially filled containers. For example, if a facility has 10 boxes of pills with 25 pill packs in each, and a partially filled box with 10 pill packs, the approximate number is 260 pill packs ([10*25]+10= 260). This question determines the approximate volume in stock; exact precision (based on recounting numerous times) is not required. Make sure to count only non-expired units (packet of pills, condom, etc.) for each contraceptive. Put the number in stock in the "Available" column. Be sure to check the expiration date – if the date is not on the unit itself, check the box or package from which it came. If there is no expiration date, do not count the item. If it is not possible to physically check the supplies, be sure to indicate that on the form.

The information regarding stockouts can come from two sources. First, ask the staff in charge of FP services or the person in charge of logistics if any contraceptive methods have ever been out of stock in the last six months. Second, try to verify whether they have been out of stock by checking the records, if available. If either the staff member or the records indicate a stockout, circle "yes" on the form. Circle "yes" for stockout if there has **ever** been a stockout in the last six months, regardless of whether supplies exist on the day of the inventory.

3. When you run out of contraceptives, how long does it take to replace them?
(ASK)
Ask the staff in charge how long it usually takes them to respond to stockouts of contraceptive methods. Mark approximately how long it usually takes for contraceptive supplies to be replaced. As indicated above, it is important to determine how fast the facility responds to stockouts because an inconsistent stock of methods can lead to limitations of method choice.

4. Which services are offered at this facility?
For each service, first record if it is provided, and then record whether the service has been available at all times in the last six months. If the service has NOT been available at all times in the last six months, mark the reason why it was last not available.

A. Type of service
B. Provided
C. Available at all times in last 6 months
D. If no, reason not available last time

(OBSERVE AND ASK)
Ask the staff in charge of FP services what other types of contraceptive services are provided at the facility from the list on the page. For this survey, "provided" means at least 3 days per week with the exception of sterilization, which will be considered "provided" if clients can receive counseling on the method on at least three days of the week and if there is a set schedule for sterilization at least once a week. Review the list of services one more time and ask if at any time in the last six months the facility was unable to offer any of the services. If the service was not available at some time in the last six months, mark "no." Then mark the reason the service was last not available in the corresponding column next to the service. Note: a particular service may have not been available several times in a 6-month period. Mark the reason it was last not available in the 6-month period. If the reason given does not correspond to the selections, briefly explain the reason in the space given. Do this separately for each service and probe to see if other services (LAM, counseling, etc.) are available.

5. When you are unable to perform family planning services, how long does it take for them to resume?
(ASK)
Ask the staff in charge how long it usually takes for them to restore family planning services when they are interrupted. Mark approximately how long it usually takes for services to resume. As indicated above, it is important to determine how fast the facility responds to a disruption in services because unreliable services can limit method choice, an important component of quality services.

6. Which of the following types of equipment are available and in working order?
(OBSERVE AND ASK)
Ask to see each type of equipment. If there is at least one available in working order, mark the corresponding box on the table. (Note: Many items will be found in "minilap kits," "IUD kits," or "no-scalpel vasectomy kits.")

This is crucial section of the facility audit. Each item on the list has been identified as necessary for a specific FP method or service. If that method or service is provided at the facility, the presence or absence of any item will greatly affect the availability and quality of the services. (Note: This list is not comprehensive, but rather includes key items for the delivery of contraceptive services.) Verify the presence of each item by asking to see it. Verify that the item is in working order by asking the staff member if it works or by checking it yourself (if you know how it is supposed to function.) Check both the clinic and the storeroom. If it is not possible to access to the storeroom, make a note of this problem in the margin and enter only the equipment seen in the clinic. For each piece of equipment, *only mark the items in working order*. If the equipment exists but is not in working order, *do not mark the box*. Many of the items listed will be found in "minilap kits," "IUD kits," or "no-scalpel vasectomy kits." If the facility has such kits, the individual pieces should be marked on the chart.

7. Are storage facilities for contraceptives adequate in the following respect:

A. Products are protected from the rain.

B. Products are off the floor and on shelves.

(OBSERVE)

Ask to see where the commodities are stored and determine whether the storage is adequate on these two criteria. If the contraceptives are exposed to these various threats, their effectiveness and safety will be compromised.

Section II Conditions of Facility

8. Verify if there is a client waiting area with seating that is sheltered from sun and rain at the clinic.

Note: The waiting area must have some form of seating for at least 10 people.

(OBSERVE)

Examine the clinic area, including the outside of the building. If there is an area specifically designated as a waiting area, which provides a roof or other shelter from sun and rain, the waiting area is sheltered. This area may be either inside or outside, but must be adjacent to the clinic. If the waiting area has no roof or other form of shelter, it does not count. A waiting area is considered to have seating if there are chairs, benches, or seating along a wall for clients such that clients are not sitting directly on the ground. If the waiting area is sheltered, but there is no seating mark "yes" and that it has "shelter." If the waiting area has seating, but is not sheltered, mark "yes" and that it has "seating." If the waiting area has both shelter and seating, mark "yes" and "both." If the waiting area has neither, mark "no."

9. Ask the respondent, "May I see where family planning clients are examined?" Choose the response that best describes where examinations take place.

(OBSERVE AND ASK)

The conditions of the examination room can dramatically affect the quality of care given as well as clients' satisfaction with the facility. It is very important that the client cannot be seen by other clients during the pelvic examination. If the facility has some mechanism other than those listed for assuring privacy (e.g., a screen), write that in the blank.

10a. What is the source of water used at the facility today?
(OBSERVE AND ASK)
The purpose of this question is to determine the cleanliness of the water available at the clinic. Mark the category that best describes the water source. Verify this answer by asking to see the source of water. A clean water source is one that is piped or a protected well or borehole.

10b. Is this source located within the compound?
(OBSERVE AND ASK)
Determine if the water source is located within the compound. Ask the manager and verify the answer by checking to see where the water source is located.

Section III IEC Materials and Activities

11. Is there a sign on the street or on the exterior of the building announcing that family planning services are available?
(OBSERVE)
Signs help clients understand that they can receive family planning services at the facility. Look for a sign that says family planning services are available at this facility. Sometimes the sign is outside near the road, and sometimes it is inside the facility building. Mark "yes" if there is a sign on the road or on the EXTERIOR of the building. If there are several signs, make a note of it.

12. Which family planning IEC materials are available?
(OBSERVE OR ASK)
Information, education and communication (IEC) materials can be valuable aids to communication, and their presence enhances the quality of services. For each item in this question, it is important that you actually see a particular IEC material to verify it is present. Look for posters on the walls or doors of the facility. Ask the staff in charge of FP services if they have flipcharts, brochures, or pamphlets. For brochures/pamphlets and information sheets, count and verify that there are at least ten of these IEC materials. If the facility has other types of IEC materials (perhaps developed by local NGOs or others), write them in the blank space by "G" (other).

Section IV Supervision

13. What was the date of the last "outside" supervisory visit which included a review of family planning services?
(OBSERVE OR ASK)
People generally tend to perform better if they know that someone is interested and concerned about their work. Supervisory visits should serve this function and thereby improve the quality of services. Ask the staff in charge of FP services for the date of the most recent supervisory visit for the purpose of reviewing services. It is important that you determine that the visits were made for supervisory purposes, not just to provide services or perform some other function. If there is a supervisor's visit record book, ask to check it. Record the date of the most recent supervisory visit from a supervisor that is not part of the clinic staff. Determine the date of the visit from the records or ask the staff member who is assisting you.

Section V Protocols and Guidelines

14. Please show me the most recent version of written guidelines and protocols for delivering family planning services.
Record "yes" if at least one set of written guidelines is available.
(OBSERVE AND ASK)
Protocols and guidelines are usually issued by the government to assure consistency in the examination and treatment of clients around the country. These guidelines reflect the national family planning program's rules and guidelines for providing services. Clinics are required to follow these guidelines. When posing this question, ask to see the guidelines and check the publication date. If the staff member shows you the guidelines mark "available and observed" and record the publication date. If the staff member is not able to show you a written set of guidelines, but is confident that they are available for use mark "available, but not observed." If there are no guidelines available mark "not available." If the staff member is not sure if guidelines exist, mark code "8" (Don't know).

15. Please show me where all of the client records are kept.
Record "yes" if client records are kept in a secure area.
(OBSERVE AND ASK)
Check to see if the clinic has a place to store client records and determine if the storage area ensures client confidentiality. An area is considered "secure" if records are stored such that only clinic personnel can access them. For example, they may be kept in a separate room or in filing cabinets that may only be accessed by staff. This is an important consideration in determining the quality of services that the client is receiving. If the clinic does have a secure place to store client records, mark "yes." If the clinic does not have a secure area for client records, mark "no." If you are not able to determine if records are stored in a secure area, mark "Don't know."

Section VI Use of Information in Clinic Management

16. What methods do you have for determining client opinions?
Read options and mark all that apply.
(ASK)
Being responsive to the demands of the client is a component of quality of care. A clinic that is receptive to suggestions from clients, or even seeks out the opinions of its clientele, is more likely to turn out satisfied customers. A clinic may have a system in place for soliciting client feedback on the quality its services. The clinic may have a suggestion box or surveys may be distributed to clients while they are in the waiting room. Providers or staff members also may seek the opinions of clients. If there are other ways in which the clinic determines client opinion, mark "other" and record the response in the space provided. If there is a way in which client opinions are determined, mark "yes" and specify the way in which clients express their opinions. If the clinic has a method to solicit client opinions, continue to question #17, if not, go to question #19. Multiple responses are permitted.

17. In the past quarter (3 months), have any changes been made in the program based on feedback from clients?

(ASK)

For this question, ask first whether any changes have taken place as a result of client opinions. If no changes have taken place, skip to question #19. If the staff report that some changes have occurred, probe to find out what changes they are referring to and describe them briefly in the blank for #18.

18. What changes have taken place?

(ASK)

Briefly describe any changes cited by the personnel that have resulted from client opinions.

19. What methods do you have for determining provider opinions?

Read options and mark all that apply.

(ASK)

A clinic may have a system in place for determining provider opinions about the quality of services at the clinic. Provider opinions may be obtained through a staff suggestion box, staff meetings, or through internal clinic evaluations. If there are other ways in which the clinic determines provider opinion, mark "other" and record the response in the space provided. Mark all responses that apply. If the clinic has a method to solicit provider opinions continue to questions #20, if not, skip to question #22.

20. In the past quarter (3 months), have any changes been made in the program as a result of provider opinions?

(ASK)

This question is similar to #16, except that the changes must have resulted from the opinions of one or more persons who provide services. This person could either be a doctor, nurse, midwife, auxiliary nurse, or other clinical personnel. This does not include administrators or other persons who do not provide services. If no changes have occurred as a result of provider opinion, go to question #22.

21. What changes have taken place?

(ASK)

Briefly describe the changes cited by the clinic staff that have resulted from provider opinion.

Section VII Service Statistics

22. How many clients received family planning services in last 4 completed quarters (12 months)? (OBSERVE OR ASK)

The purpose of these questions is to assess the client load by service for family planning, at each facility. This can help test the association between quality of services and service utilization. Ask to see the facility's service statistics records for the past four COMPLETED quarters. In the table, fill in the total number of new FP acceptors (clients using a contraceptive method for the first time) and total FP visits. Total visits include new acceptors and continuing users. If you have any problems reading the statistics, make a note in the margins. Code "9999" if the statistics are not available.

23. Overall, how many client visits for MCH, FP, and general exams were recorded at this clinic in the last 4 completed quarters (12 months)?
(OBSERVE OR ASK)
Record the total number of client visits at this clinic in the past four quarters. Client visits include any type of service that the clinic offers (MCH, FP, immunizations, general health exam, etc.).

24. On an average day, how many providers are available to see family planning clients?
(ASK)
Quality of care may be linked to the patient load of the provider. Providers with a high patient load do not have a lot of time to devote to each patient. This could affect the quality of services that each client receives. Because the number of clinical service providers may vary from day to day, record the average number of providers that are available to see clients on a given day.

IMPORTANT: At the end of the inventory, double-check your responses to make sure you did not leave any questions blank. If need be, double-check your answers with the clinic staff.

Module 4: Observation of Client-Provider Interaction (CPI)

- Tool
- Guidelines

Overview

The observation of the client-provider interaction (CPI) is important because it provides information about the exchange between the client and the provider from the perspective of a clinician. The observation of the interaction between the client and the provider supplies important information regarding how the client is counseled, examined and provided with a contraceptive method. While the observation guide is divided into sections, the client-provider interaction may not follow the sequence of the observation guide.

Tips for Observers[15]

The observation of the interaction between the client and the provider supplies important information regarding how the client is counseled, examined and provided with a contraceptive method. Observers should be medically trained and have experience in providing family planning. Typically, observers are physicians, nurses, or nurse midwives who have both experience and training in implementing family planning. Because these observers have experience and training, they are able to effectively evaluate the client-provider interaction. This part of the study requires excellent listening skills and attention to detail during the observation.

Know the contents and sequence of the observation guide

The observation guide is divided into sections, but the client-provider interaction may not follow the sequence of the observation guide. As a result, it is extremely important that the observer learn the content and order of the observation guide so that, when s/he sees an action or hears an issue discussed, s/he will know precisely where the item is contained within the guide. At times, the observer may need to mark items after the consultation is complete.

Obtain permission to observe client-provider interaction

Observers must receive permission from the provider(s) to sit in on the examination and consultation. Providers should be made aware beforehand that the observer **cannot** participate in the consultation. The observer should not offer his/her advice or opinions **unless** the provider performs an action that threatens the patient's health. Before the observation begins, the provider should be asked to act as he/she would in the absence of the observer. Because the presence of the observer will inevitably affect the client-provider interaction, the observer should make himself/herself as unobtrusive as possible.

Be aware of new versus continuing users

In the observation guide, some questions apply to ALL clients (**both** continuing users and new users), and some only apply to new users. For the purposes of this study, a **new user** is a client who is either a new contraceptive user, is restarting contraceptive use, is switching contraceptive methods or is new to the facility. A **continuing user** is a client who is a current user, is coming in for a follow-up visit, or

[15] The "tips" for observers were largely drawn from *The Situation Analysis Approach to Assessing Family Planning and Reproductive Health Services: A Handbook* (Miller et al., 1997).

is having a problem with a method. It is very important that you know how to distinguish between these two types of clients. Instructions appear within the observation guide as to what items apply to which type of family planning client.

Dress and act appropriately while observing

Before the start of the consultation, the provider should find out if it is acceptable for an observer to be present. During the observation, the observer should make every effort to sit in the background such that s/he does not make eye contact with either the client or the provider. Observers should wear appropriate clothing such as a nursing uniform or a white coat. Observers should be matched by sex with the client, in that female clients would have female observers and male clients would have male observers.

Link the observation with the client's exit interview

At the close of the observation, the observer should ask the client if s/he would agree to be interviewed. If s/he agrees, lead the client to the person administering the client exit interview. Be sensitive to the fact that s/he may have been at the clinic for a long time. Emphasize the importance of the client's participation in the study, and respect his/her wishes if s/he chooses not to participate in the client exit interview. Be sure to check that the client number on the observation guide corresponds with the client number on the client exit interview.

Review the instruments

At the conclusion of the observation, it is extremely important that you take time to review the instrument in order to verify which items contained within the observation guide took place during the consultation.

INSTRUCTIONS TO OBSERVER:

When a family planning client arrives at the health facility, ask the client if s/he is willing to let you observe the visit and to answer a few questions afterwards about the services s/he has received. It is essential that you gain informed consent before beginning the observation, so the following greeting should be given. After reading the greeting, sign and date the statement that indicates whether or not the client agreed to participate.

GREETING

"Hello. My name is _____ and I am a physician/nurse/midwife/medical student. I am from _____. We are doing a survey to find out about the services provided at this clinic. The information from the survey will be used to improve the quality of services in this and other clinics. The clinic has given us permission to do the survey and we are asking all family planning clients who visit the clinic today to participate. We would like your permission to observe your visit with the clinic staff and to ask you a few questions about the visit afterwards.

Your participation is extremely important, but it is entirely voluntary. You do not have to be observed, nor do you have to answer any questions if you do not want to. You will not be denied any services if you decide not to participate. If you agree to participate in the survey, you can change your mind at any time during the visit or the interview. I will not write down your name and everything you tell me will be kept strictly confidential. During your visit, I will be sitting a little apart from you and the clinic staff. There are no risks or direct benefits to you from participating in the survey but your participation will contribute to improving services in this and other clinics.

Do I have your permission to continue?" CHECK BOX: ☐YES ☐ NO

READ AND SIGN THE FOLLOWING:

IF YES, SIGN AND DATE THE STATEMENT BELOW AND CONTINUE WITH THE OBSERVATION.

I certify that I read the statement above to the client and s/he agreed to participate in the study.

Signed _____, Date _____

IF NO, SIGN AND DATE THE STATEMENT BELOW AND THEN STOP AND WAIT FOR ANOTHER CLIENT.

I certify that I read the statement above to the client and s/he did not agree to participate in the study.

Signed _____, Date _____

Observation Guide for Counseling and Clinical Procedures

Observation ID number: ☐☐

01 Health Facility (Name & Number) : _____ ☐☐☐

02 District (Name & Number) : _____ ☐☐☐

03 Region (Name & Number) : _____ ☐☐

04 Provider (Name & ID Number) : _____ ☐☐

05 Date of Observation: ☐☐ **Day** ☐☐ **Month** ☐☐ **Year**

06 Observer (Name & Number): _____ ☐☐

07 Type of Facility Where Observation Took Place:

- ☐ Referral Hospital
- ☐ Hospital
- ☐ FP Clinic
- ☐ Health Center
- ☐ Health Post
- ☐ Mobile Health Clinic
- ☐ Clinics in Non-permanent Facilities (schools, rotating rural health outposts, etc.)
- ☐ Other_____

Identification Number : ☐☐ Region ☐☐☐ District ☐☐☐ Facility ☐☐ Observation

08 Type of Sector :

- ☐ Government/ MOH
- ☐ Government/ other
- ☐ FP Association (IPPF affiliate)
- ☐ Other NGOs
- ☐ Missionary
- ☐ Private
- ☐ Other

09 Locality of Facility:

☐ Rural ☐ Urban ☐ Peri-urban

10 Time Observed Session Began: ☐☐ : ☐☐
(use military time)

11 Provider providing MOST of the Counseling session:

- ☐ Nurse
- ☐ Nurse- Midwife
- ☐ Doctor
- ☐ Health Worker
- ☐ Other _____

12 Sex of Provider:

☐ Female ☐ Male

13 Sex of Client:

☐ Female ☐ Male

Counseling Observation Guide
FOR ALL CLIENTS
Mark (X) as appropriate

20. Family planning status upon arrival at this facility:

☐ Non-user, but past use ☐ Current user
☐ Non-user, no past use ☐ Not determined

21. Language spoken:

☐ Language A ☐ Language B ☐ Language C
☐ Other _____

22. Previous contact with provider:

☐ Yes ☐ No ☐ Not determined

23. Did the provider:	Yes	No
A. Ask open-ended questions		
B. Encourage client to ask questions		
C. Treat client with respect		
D. See client in private		
E. Discuss a return visit		
F. Ask client his/her concerns with any method		
G. Use visual aids		
H. Use client record		
I. Assure client of confidentiality		

Information Discussed: *Mark who initiated the conversation or mark "not discussed"*	Provider asked	Client provided	Not discussed
A. Current age			
B. Marital/ relationship status			
C. Number of living children			
D. Desire for more children			
E. Timing of next child			
F. Current pregnancy status (females only)			
G. History of pregnancy complications (females only)			
H. Partner's attitude about FP (approve/disapprove)			
I. Multiple/single sexual partner(s)			
J. Partner multiple/single sexual partner(s)			
K. HIV/AIDS and STIs discussed			
L. History/signs/symptoms of STIs			

25. Outcome of visit: ☐ **Information / Counseling only**

☐ **Continuing clients / same method**
☐ resupply/routine follow-up
☐ restart same method (< 6 months)
☐ discuss problem with method

☐ **New clients/ changed method:**
☐ receive method first time ever or at this site
☐ restart (> 6 months)
☐ switch contraceptive method

26. Method actually received / prescribed (new clients) or came/left with (continuing clients):

☐ Pill
☐ IUD
☐ Injectable
☐ Implant
☐ Vasectomy

☐ Female sterilization
☐ Condom
☐ Spermicide
☐ Rhythm/periodic abstinence

☐ LAM
☐ Diaphragm
☐ Condom + other____
☐ Other_____
☐ No method

***NEW* CLIENTS ONLY**
Mark (X) as appropriate

27. Client stated preference for method:

- ☐ Pill
- ☐ IUD
- ☐ Injectable
- ☐ Implant
- ☐ Vasectomy
- ☐ Female sterilization
- ☐ Condom
- ☐ Spermicide
- ☐ Rhythm/periodic abstinence
- ☐ LAM
- ☐ Diaphragm
- ☐ Condom + other
- ☐ Other_____
- ☐ No preference **(GO TO Q31, No preference only)**
- ☐ Preference not discussed **(GO TO Q29)**

28. Preferred method received (for clients who state a preference):

☐ **Yes**

☐ **No** → **(GO TO Q30)**

29. Provider determined client's reason for method selection:

☐ Yes
☐ No

(GO TO Q31)

MARK ONLY IF CLIENT DID NOT RECEIVE PREFERRED METHOD	
30. Reason preferred method not received:	**(X)**
A. Not available in clinic that day	
B. Not available at all	
C. Not available, referred to another source or clinic	
D. Not appropriate method (contraindications)	
E. No appropriate provider available that day	
F. Provider recommended another method	
G. Changed mind after listening to provider	
H. Client did not make choice at time of session	
I. Client not at risk of pregnancy	
J. Pregnancy suspected	
K. Told to return during menses	
L. Client could not pay for services today	
M. Other _____	
N. Not clear why	

NEW CLIENTS BY METHOD RECEIVED OR PRESCRIBED

Circle the method that the client received or was prescribed and mark (X) as appropriate.

31. Method Selection Matrix

Did Providers:	Pill	IUD	Injectable	Implant	Female Sterilization	Vasectomy	Condom	Spermicide	Rhythm/ Periodic Abstinence	LAM	Diaphragm
A. Check Blood Pressure											
B. Check/Ask Pregnancy											
C. Ask About Smoking											
D. Ask about Breastfeeding											
E. Provide # Condoms or Cycles											
F. Ask About Chronic Health Problems											
G. Ask about Allergies to Latex											
H. Ask about Last Delivery Date											
I. Ask about Pregnancy Complications											
J. Ask about Regularity of Menstrual Cycle											

32. Provider gave accurate information about key point:
(See guidelines below)

	Yes	No
A. How to use		
B. Side effects		

Contraceptive Methods Guidelines		
Method	**How to Use**	**Side Effects**
Pill	Must be taken every day	Nausea, spotting
IUD	Should check strings	Menstrual bleeding
Injectable (i.e., Depo Provera)	Provides protection for 3 months	Menstrual changes
Implant	Provides protection for 5 years	Menstrual changes
Female Sterilization	Can never become pregnant again	Pain at surgical site
Vasectomy	Should be considered irreversible-cannot impregnate again	Pain at surgical site
Condoms	Use once	Allergy to latex
Spermicide	Must insert 15-60 min before intercourse	Tissue irritation
Rhythm/ Periodic Abstinence	Should not have sexual intercourse during the fertile period.	
LAM	Should not use once menstrual period has returned	
Diaphragm	Must leave in place 6 hours after intercourse	Bladder infection

Do not mark #33 if client has selected condoms as his/her method.

33. Did the provider:	Yes	No
A. Explain method does not protect against STIs and AIDS		
B. Encourage use of condoms as 2nd method		

Clinical Observation (Females Only)

40. Clinical provider same person who provided counseling:
☐ Same person **(go to Q43)** ☐ Different person

41. Provider performing MOST of clinical examination:
☐ Nurse ☐ Nurse- Midwife ☐ Doctor
☐ Health Worker ☐ Other _____

42. Sex of Provider:
☐ Female
☐ Male

43. OBSERVATION CONDUCTED FOR:	Yes	No
A. Client received injectable – *if yes, complete section A*		
B. Client underwent pelvic exams – *if yes, complete section B*		
C. Client had an IUD inserted – *if yes, complete section C*		

For each item, mark (X) "yes," "no," or "N/A" (not applicable) as appropriate.

A. Injectables (Depo Provera)

Did the provider:		Yes	No	N/A
D-1.	*(NEW CLIENT)* Reconfirm client's method choice			
D-2.	*(NEW CLIENT)* Verify client is not pregnant			
D-3.	*(CONTINUING CLIENT)* Give injection at correct time			
D-4.	Wash hands <u>before</u> injections			
D-5.	*(If re-usable)* Use newly reprocessed needle and syringe			
D-6	Stir/mix bottle <u>before</u> drawing dose			
D-7.	Clean and air-dry injection site <u>before</u> injection			
D-8.	*(If gluteal)* Inject in upper outer quadrant			
D-9.	Draw back plunger <u>before</u> injection			
D-10.	Allow dose to self-disperse instead of massaging			
D-11.	Dispose of sharps in puncture resistant containers			

B. Pelvic Exams

Did the provider:		Yes	No	N/A
P-1.	Ensure client has privacy			
P-2.	Prepare all instruments <u>before</u> exam			
P-3.	Wash hands <u>before</u> exam			
P-4.	Use sterilized or high-level disinfected instruments for each exam			
P-5.	Put on new or disinfected gloves <u>before</u> exam			
P-6.	Inspect the external genitalia			
P-7.	Ask the client to take slow, deep breaths, and relax all muscles			
P-8.	*(If used)* Explain speculum insertion procedure to client			
P-9.	Inspect the cervix and vaginal mucosa			
P-10.	Perform bimanual exam gently and without discomfort to client			
P-11.	Ensure that instruments and reusable gloves are decontaminated			

C. IUD Insertion

Did the provider:		Yes	No	N/A
I-1.	Ensure client has privacy			
I-2.	*(NEW CLIENT)* Reconfirm client's method choice			
I-3.	Use sterilized or high-level disinfected instruments			
I-4.	Wash hands <u>before</u> putting on gloves			
I-5.	Glove hands			
I-6.	Conduct speculum exam for RTI/STIs <u>before</u> bimanual exam			
I-7.	Conduct bimanual pelvic exam			
I-8.	Visualize cervix during cleaning			
I-9.	Use tenaculum			
I-10.	Sound the uterus <u>before</u> IUD insertion			
I-11.	Use the no-touch technique for inserting the IUD			
I-12.	Wash hands <u>after</u> removing gloves			
I-13.	Ask client to wait/rest for at least 15 minutes after insertion			
I-14.	Wipe contaminated surfaces with disinfectant			
I-15.	Ensure that instruments and reusable gloves are decontaminated			

Time Observed Session Ended: ☐☐ : ☐☐
(use military time)

Observation Guidelines

Overview

Observation of the interaction between the client and the observer supplies important information regarding how the client is counseled, examined, and provided with a contraceptive method. Observing a client seeking health services is difficult and time consuming. Consequently, the quality of the information not only depends on the observer's ability and awareness, but also his/her adherence to a number of guidelines that are briefly described below:

- Because the observed session is not likely to follow the order of the observation guide, the observer should be prepared to skip from place to place within it to record actions, and should thoroughly review it after the session to ensure that it is complete and accurate.
- Activities recorded as observed or unobserved may change as the session progresses. For example, a client may at first seem to only want "information and/or counseling," but may decide to accept a contraceptive method for the first time and thus be a "new user" by the end of the session. In a like manner, an action may occur out of sequence. For example, blood pressure may be taken at the end of the session after a method has already been provided. It is acceptable to change answers as the events warrant.
- Actions by the provider or client may be very subtle and as a result the observer must pay complete attention to what is going on in the session. Observers must watch body language, listen to the tone of voice, and observe non-verbal communication such as a nod or shake of the head. Make sure the counseling room is arranged to ensure clear visibility of both the client and provider.
- Observers must pay attention to the counseling session without being intrusive. To that end, observers should avoid clicking pens, shuffling pages, making eye contact with the provider or client, speaking, or doing anything that may disrupt the client-provider interaction.
- Some observers may prefer to observe the session closely, making limited marks in the observation guide, and completing the remainder of the guide immediately following the session.
- Consistency is important to ensure the quality of the information. Be sure that all observers interpret actions occurring during the session in the same way. If a question arises, the observer should make a note on the observation guide and ask the supervisor to clarify the appropriate way to record the activity.
- If at any time during the session the observer is clearly distracting the provider or the client, or if the client asks the observer to leave, the observer should politely withdraw.

Before the start of the observation, you must obtain both the verbal consent of the provider and the written consent of the client to observe the session. While it is not necessary to give a detailed explanation of why the session is being observed, respond politely to any questions asked.

This study had defined "new" and "continuing" family planning users in a way that may be different than the standard for other programs. These definitions are important to the understanding of each session, and thus should be consistently applied.
A **"new client"** is a client whose reason for visiting the clinic is

- **to receive, get prescribed or referred for** a contraceptive method for the first time ever, or for the first time at this site;
- **to restart** contraceptive method use (after not using for 6 months or more); or
- **to switch** contraceptive methods or restart a different method (after any length of time).

A **"continuing client"** is a client who has used the clinic before and is visiting for the following reasons:

- **to get supplies** or to have a routine follow-up for a method s/he is already using;
- **to restart same method** (after not using for less than 6 months); or
- **to discuss a problem** with a method s/he is currently using.

Note: A client may come for one of the above reasons, but if s/he is new to the facility s/he is considered a new client. Likewise, a client who switches methods is considered a new client even if s/he has visited the clinic before. A person who comes to the clinic to get information and/or counseling about a contraceptive method may be either a "new client" or a "continuing client." In the observation guide, a person who comes in for information and/or counseling and does not leave the clinic with a method, should be treated as a continuing client. In the observation guide, some questions apply to ALL clients (both "new" and "continuing"), and some apply only to "new clients." Instructions for the observer appear throughout the observation guide *in bold italics*.

Identification Number

Country Specific. The number of digits for the identification number will be different in each country. For example, some countries may not have both regions and districts. This ID number uniquely identifies each observation. The codes should be entered in the following sequence: region, district, facility, and then observation. The observation number will also be used on the client exit interview if the person observed is subsequently interviewed. These numbers may be assigned specifically for this study or an existing facility ID number may be used.

Observation ID Number

Record the number assigned to the client. This number will identify the client for both the clinical observation and the client exit interview. If more than one observation takes place simultaneously, the observation ID numbers (and exit interviews) may not be sequential. Some countries may assign observation ID numbers after the session in order to allow sequential numbering. In any case, the system should be determined by the principal investigator and used by all teams.

01. Health Facility (Name and Number)
02. District (Name and Number)
03. Region (Name and Number)

04. Provider (Name & ID Number)
It is important that the correct numbers and names are recorded for the observation identification, health facility, district, region, and provider. The supervisor or the team leader should make sure that the correct numbers are recorded here.

05. Date of observation
Record today's date here. Record the day first, then the month, followed by the year. For example, if the date is April 14, 2001 write: 1 4 0 4 0 1 .

06. Observer (Name and Number)
Record the name and the assigned number of the observer conducting the observation here.

07. Type of Facility where the Observation Took Place
The type of facility refers to the services offered. The types will vary by country, but should reflect the actual structure of health facilities available in the country.

08. Type of Sector
Sector type describes the sponsoring agency for the facility. The types will vary by country. If there is any question about the type (e.g., multiple sources of financial, staffing, or commodity support), refer the selection to a supervisor.

09. Locality of Facility
Country specific. Mark the appropriate locality in which the facility operates. The locality is usually determined administratively. It may be necessary to ask local officials. Urban clinics can appear to be in a rural area and be serving a rural population. For example, some countries may denote only "rural" and "urban" areas. Adapt the locality to reflect the situation in your country.

10. Time Observed Session Began
Write down the exact time that the observation begins using a 24-hour clock (military time). For example, 8:35 AM is recorded as 08:35, and 8:50 PM is recorded as 20:50.

11. Provider providing MOST of the counseling session
Mark which type of provider conducted MOST of the counseling session.

12. Sex of Provider
Mark whether the provider is female or male.

13. Sex of Client
Mark whether the client is female or male.

NOTE: You may not continue with the observation until you have the consent of BOTH the client and the provider who is conducting the counseling session and the examination. You may continue when BOTH have consented to the observation. If the client refuses to participate, mark the appropriate box. It is important that there be a record of those who have refused to participate in the study. To that end, the research team should keep all instruments where the client has refused to participate, and this information eventually should be recorded as a variable in the data set, and used to track the non-response rate.

Counseling Observation Guide

Item-by-item guide

Instructions: Below are the items found in the counseling and the clinical sections of the observation. The items are in **boldface** type, and the instructions about each item are below it. Before observing a client, be sure to read through this item-by-item guide so that you understand each item.

For ALL CLIENTS: Mark (X) as appropriate.
NOTE: the following items apply to all clients (both new and continuing).

20. Family planning status upon arrival at this facility

We want to know if the client is at risk for an unwanted pregnancy at the time of his/her visit. If the family planning status of the client is determined through the course of the observation, mark the category that best fits the client you are observing. The provider may determine the family planning status of the client by looking at his/her written record, by asking the client his/her status, or the client may tell the provider what his/her family planning status is. The categories of family planning status are defined below.

- **Non-user, but past use**
- **Non-user, no past use**
  There are two types of non-user. There are those who are currently non-users, but have used a contraceptive method in the past, and those who are non-users and have never used a contraceptive method in the past. If the client is not currently using a method, try to determine through observation if s/he has ever used a contraceptive method in the past. Initially, it may not be clear which type of non-user the client is. For example, s/he may say: "I am not currently using a method." Here, it is not clear if s/he has ever used a method or not. If you are able to distinguish which type of non-user the client is, mark which type of non-user s/he is. If you can only determine that s/he is a non-user assume the client is a non-user with no past use.
- Current user
  A client who on the day of the interview is protected from an unwanted pregnancy is a **current user.** A woman who is using a pill that has a 21-day cycle and is not taking a pill today (because she is menstruating) is a **current user,** because even though a client is not using a contraceptive method **today**, she is still protected from an unwanted pregnancy.

- Not determined
  If you are not able to determine whether the client is a past or current user, mark not determined.

21. Language spoken

Country specific. Country specific languages should be pre-coded here.
Mark the language that is spoken the *most* throughout the consultation. If two languages are spoken equally throughout the session, mark both languages.

22. Previous contact with provider

If the client has had previous contact with the provider, the provider may or may not cover some items in the session. Previous "contact" in this case refers only to family planning services. In integrated services the client may have had contact for curative or immunization services. This should not be considered "contact." If either the client or the provider states (directly or indirectly) that they have had previous contact, mark the correct box. If you are unable to ascertain if they have had previous contact mark "not determined." The following are cues that the provider and the client have been in contact with one another before:

- **Provider:** "It is nice to see you again Maria." Or, "You're a little late for your appointment. Have you had any problems since your last appointment?"
- **Client:** "I have experienced sharp abdominal pains since my last examination here." Or "Why do I have to keep coming back to get my supply of pills?"

23. Did the provider:

A. Ask open-ended questions

Closed-ended questions are questions that require a limited or one-word answer from the client: "yes, "no," "17 years." Open-ended questions invite further conversation on a particular topic. Providers may encourage clients through open-ended questions such as:

- "How do you feel about the contraceptive method you have chosen?"
- "What do you think about . . .?"
- "Why have you chosen . . .?"

Here, the provider uses open-ended questions to encourage an open dialog with the client. If <u>any</u> of the questions asked by the provider are open-ended, mark "yes."

B. Encourage client to ask questions

A provider can give the client many opportunities to ask questions. Here are some examples of how the provider may encourage the client to ask questions:

- "Do you have any questions?"
- "Do you understand?"
- "Is there anything else you need to know?"

A provider may **discourage** the client from asking questions by not providing an opening for him/her to speak in the conversation, or by interrupting him/her when s/he asks questions. If the provider encourages the client to speak during the session, mark the "yes" box.

C. Treat client with respect

Country specific. This question should be adapted to reflect the country specific ways in which a provider may treat a client with respect. Training about the standards of respect is important to ensure that all observers are defining respectful or disrespectful behaviors in the same way. The provider may show respect by greeting the client in a friendly manner and by using his/her full proper name. The provider may also show respect through his/her body language. Some examples of respect through body language include shaking hands with the client and making eye contact when speaking to him/her. Providers also show respect by responding to client questions. The provider may disrespect the client by interrupting him/her, scolding or yelling at him/her, or by not making eye contact.

D. See client in private

Determine if other clients or staff (other than those caring for the client) can hear or see the client. Check to see if the client is behind a screen or in a room such that only those people directly caring for the client can hear or see him/her. The client's privacy is respected if the provider speaks in low tones, if there are no extra staff in the room, and if the session is not interrupted. Client privacy is also respected by providing counseling to one client, or one client and partner, at a time.

E. Discuss a return visit

Determine if the provider gives some type of instruction to the client regarding his/her return to the facility. The provider may ask the client to return for a visit on a specific date, or for an unspecified time in the future. For example:

- **Specific:** "Make an appointment at the front desk to come back in 2 weeks. I want to make sure that you are not having any complications with the contraceptive method that you have chosen." Or,
- **Non-specific:** "Come back during May," or, "Come back to the clinic when you need a refill for the pills or if you have any questions or concerns."

F. Ask client his/her concerns with any method

This item is similar to "encouraging the client to ask questions," but we are interested in if the provider specifically asks about concerns with a contraceptive method or if the provider gave the client an opportunity to ask questions about any method. A client may have questions about many methods (especially if s/he is a new user), a specific method, or contraception in general, which the provider's questions will bring out.

G. Use visual aids

Providers may use information, education and communication materials to help explain the points they are trying to make. These visual aids communicate information to clients in a different manner

than language does. Examples of commonly used visual aids include: flip charts, posters, anatomical models, samples of contraceptive methods, and pamphlets used in instruction and then given to the client.

H. Use client record

The use and availability of visual aids will vary by country. If the provider refers to a client record during the course of the consultation, check "yes." A new user may have a record if the provider fills one out today, or if other clinic staff filled out a record for him/her prior to the consultation. A continuing user may carry his/her card into the clinic if s/he has been to this clinic before, or s/he may have a record on file at the clinic. In some countries or programs, clients may carry their cards/histories with them from facility to facility. However, if the provider does not look at the card or looks at it only after the session, mark "no."

I. Assure client of confidentiality

In order for the client to feel comfortable and to provide sensitive information on his/her circumstances or medical history, it is important that the client be told that the information that s/he provides will be kept confidential. The provider should assure the client that information s/he shares will not be disclosed to anyone except the clinic staff, and that it will not be discussed outside of the clinic setting.

For each item below in #24, if the topic is discussed, mark who initiated the conversation ("provider asked" or "client provided"). If the topic is not discussed, mark "not discussed."

24. Information provided:

A. Current age

A client may either state his/her date of birth, or s/he may state his/her age as a number. It is not important if the client's exact age is discussed. If his/her approximate age is discussed during the session, mark the appropriate box.

B. Marital/relationship status

Note whether or not the client's marital/relationship status is discussed. Do the provider and client talk about if the client is in a monogamous relationship (such as marriage) or not? The client may say that s/he is married or divorced, or s/he may make a reference to her steady boyfriend/girlfriend or husband/wife.

C. Number of living children

The provider may ask the client how many children s/he has, or the topic may arise naturally while discussing a suitable contraceptive method. A client has living children even if they are not currently staying with him/her. Children that the client is watching for someone else (e.g., his/her sister's children) are not considered his/her children.

D. Desire for more children

A client may wish to stop having children, or to delay or space future births. Mark if the client's desire to have children is discussed. For clients who do not have children, mark if their desire for any children is discussed. For clients that already have children, mark if their desire for more children is discussed.

E. Timing of next child

Do not mark if the client does not want any more children.

If the client and the provider discuss when the client would like to have his/her next child, mark who brought up the topic. For example, a client may say: "I do no want to have another child until my first-born child is 2 years old."

F. Current pregnancy status (females only)

There are three situations that could arise in the counseling session regarding the client's current pregnancy status. The client may say she is not pregnant, she is pregnant, or she is not sure if she is pregnant. The provider may ask other probing questions to determine pregnancy status if the client is unsure. For example, the provider may ask if the client has any signs or symptoms of pregnancy (e.g., tender breasts or nausea) or the client may mention these signs and symptoms. If pregnancy status in particular is discussed or if signs or symptoms or pregnancy status are discussed, mark who initiated the interaction on this topic. If this is not explicitly or indirectly discussed, mark "not discussed."

G. History of pregnancy complications (females only)

Do not mark if the client has never been pregnant.

There are several complications that a woman might have had in a previous pregnancy. Some examples of pregnancy complications are: Cesarean section, extended labor, infection, hemorrhaging, etc. If any of the above complications are discussed, or any vague mention of the client having troubles during a pregnancy is discussed, mark the appropriate box. Note: A client who does not have any children may have had a previous pregnancy complication.

H. Partner's attitude about family planning (approve/disapprove)

The client's partner may approve or disapprove of family planning. Either the client or provider may mention the topic. For example:

- **Provider:** "You have decided to be sterilized. Have you discussed this with your husband? Is he in favor of this irreversible method?" or,
- **Client:** "My husband does not want me to be sterilized. He wants to have more children in the future." If partner's attitude toward family planning is discussed, mark the appropriate box.

NOTE: The following topics address potentially sensitive topics. As a result, both the provider and the client may discuss these issues in a subtle manner. Be sure to pay attention to subtle cues that indicate that these topics have been addressed.

I. Multiple/single sex partner(s)

There may be a discussion in which the client mentions that s/he has only one partner, or the client may explicitly talk about or make subtle references that indicate that s/he has multiple sexual partners. If the issue of his/her sexual relations is addressed, mark who initiated the discussion. For example, the client may say: "I have a girlfriend that I have been going steady with for the past 2 years." This is an indication that the client has a single sex partner. Note that a box is marked if the issue is discussed. The outcome of the discussion, for example the number of partners the client has, is not required.

J. Partner multiple/single sex partner(s)

There may be a discussion of the sexual practices of the client's partners. For example, a client may say: "I think my boyfriend has another girlfriend that he sees on weekends." The provider may ask, "Do you have any of the risk factors for getting a sexually transmitted disease…like your partner has other wives or girlfriends?" If there is a discussion of the issue, mark the box of the person who initiated the conversation. Note that a box is marked if the issue is discussed. The actual number of partners the client's partner has is not required to mark a box.

K. HIV/AIDS and STIs

If there is any discussion about HIV/AIDS or STIs mark that this topic has been addressed. There are a number of ways that this topic could be addressed in the counseling session. The provider may ask the client if s/he knows of ways to protect himself/herself from HIV/AIDS and STIs. The client may say: "I am worried that I may be at risk for AIDS."

L. History/signs/symptoms of STIs

If there is any discussion about a history of STIs or current signs or symptoms of STIs, mark that this topic was discussed. Some typical signs and symptoms of STIs include: unusual discharge from the genitalia, itching or sores in or around the genitalia, and pain or burning during urination.

25. Outcome of visit

As previously stated, a **"new client"** is a client whose reason for visiting the clinic is

- **to receive, get prescribed or referred for** a contraceptive method for the first time ever, or for the first time at this site;
- **to restart** contraceptive method use (after not using for 6 months or more); or
- **to switch** contraceptive methods or restart a different method (after any length of time).

A **"continuing client"** is a client whose reason for visiting the clinic is

- **to get supplies** or to have a **routine follow-up** for a method s/he is already using;
- **to restart** same method (after not using for less than 6 months); or
- **to discuss a problem** with a method s/he is currently using.

A person who comes to the clinic to get information and/or counseling about a contraceptive method may be either a new client or a continuing client. In the observation guide, a person coming in for information and/or counseling should be treated as a continuing client. On the observation guide,

first mark for the main outcome of the visit (e.g., continuing client), and then mark the subcategory that best describes him/her. For example, in the case where the client may have run out of condoms and is interested in renewing his supply, first mark the box for "continuing client" and then mark the box for "resupply/routine follow-up." Last, answer the subsequent questions for a "continuing client." If client mentions that she is interested in getting information about the pill, mark "information/ counseling," and continue as if the client is a "continuing client." If she currently uses condoms but would like to switch to the pill, mark that she is a "new client," and also mark that she has decided to "switch contraceptive methods."

NOTE: If you are not sure what the "outcome of the visit" will be as you are observing, assume the client is a new client and conduct the observation as such.

26. Method actually received/prescribed (new client) or came/left with (continuing client)
For the client that leaves the clinic with a method or prescription for a method, mark that method (pill, IUD, sterilization, etc.). If the client did not receive a method, mark "no method." If the client does not receive a method, but does receive a pelvic exam, continue to the clinical observation and mark as appropriate. For new clients, including all clients who switch methods, mark the method they accepted and received. For continuing clients, mark the method with which they arrived and left. If the client is using both the condom and another method, mark "condom + other" and fill in the name of the "other" method.

<u>NEW</u> CLIENTS[16] ONLY:
NOTE: The following items should be marked for new clients only.

27. Client stated preference for method
If the client expresses a preference for a specific method during the session, mark the appropriate box next to that method. In stating his/her preference, the client should spontaneously mention a specific method. If the provider mentions a method and the client agrees, that is not spontaneous and should not be counted (check "no preference" and go to item #31).

In some instances, a client may have a preference for **more** than one method. Try to determine a first preference for a method through the context of the conversation between the provider and the client. If you cannot determine a first preference from the discussion and the client leaves with one of the methods for which s/he stated a preference, mark that method. If the client gives multiple responses or vague responses ("a hormonal method") and you cannot identify a single preferred method from the dialogue, mark "no preference" and go to item #31.

A client may come into the counseling session with a vague idea of which method s/he would like and then change his/her mind after s/he has learned about other methods. If a client spontaneously states

[16] For the purpose of this study a "new client" is a client who is either a new contraceptive user, is restarting contraceptive use (after stopping for 6 months or longer), is switching contraceptive methods, or is new to the facility.

a preference for more than one method during the session, mark the name of the method that s/he states last. For example, if a client says she is thinking about the pill, but changes her mind and later says that she would like to use Depo Provera, mark her preferred method as injectable (Depo Provera). If the client *does not* state a preference for a method, mark that s/he has "no preference" and go to item #31. If method preference is not discussed at all, mark "preference not discussed" and go to #29.

28. Preferred method received (for clients who state a preference)
If the client receives the method that s/he prefers, mark "yes." If the client does not receive the method that s/he preferred, mark "no" and go to item #30. For example:

- If the client prefers an implant, and leaves the clinic with an implant, mark that she has left with her preferred method.
- If a client tells the provider that she prefers Depo Provera and the clinic is not currently stocked with Depo Provera, she may leave the clinic with the pill instead. This client *did not* leave the clinic with her preferred method. First mark "no" to indicate that the client did not receive her preferred method. Next, in #30, mark that the method (Depo Provera) was "not available at the clinic that day."

29. Provider determined client's reason for method selection
Clients may select a method for a range of reasons and experiences that were not part of the session being observed. Providers should ask clients why they selected a specific method to ensure that the receiver has made an informed choice. Mark "yes" if the provider determined the client's reason for method selection and go to item #31.

30. Reason preferred method not received
Mark the reason that best describes why the client did not get the method s/he wanted. If the reason the client did not receive his/her method is not one of the categories listed, mark "other" and write down the reason. If you cannot determine why the client did not receive his/her preferred method, mark "not clear why."

NEW CLIENTS BY METHOD RECEIVED OR PRESCRIBED

These items are only for new clients who have received or have been prescribed a method today. Do not mark for clients who have been referred for procedures that are not performed at the clinic today (e.g., sterilizations are only performed on Mondays and today is Tuesday) or for procedures that are not usually provided at this clinic.

31. Method Selection Matrix
Using the matrix provided on the observation guide, mark if the provider checked the items listed for the contraceptive method that the client accepted. For example, if the client accepted an injectable (e.g., Depo Provera), mark if the provider checked her blood pressure and asked about her pregnancy status. Do not fill in the boxes that are shaded in.

Note that while an "X" is sufficient for most answers, under condoms and pills there is a space that requires you enter the number of condoms or the number of pill cycles distributed to the client. If you cannot see the actual number, ask the provider after the session.

32. Provider gave accurate information about key point
(See guidelines below)

A. How to use
B. Side effects

There are several pieces of essential information that a client needs to know about how to use a method and identify its side effects. The guidelines below provide the most essential piece(s) of information on "how to use" and "side effects" for a given method. Mark "no" if the provider does not cover the information contained in the "Contraceptive Method Guidelines" for the method that the client received or was prescribed. If the provider does cover both pertinent pieces of information, mark "yes" in both boxes. For example:

- The client has decided to be sterilized. If the provider tells the client that she can "never become pregnant again," mark "yes" in the "how to use" box.
- If the provider fails to tell her that she will have "pain at the surgical site," mark "no" in the "side effects" box.

Do not mark #33 if the client is currently using condoms.
33. Did the provider
A. Explain method does not protect against STIs and AIDS
If the provider mentions that the method does not protect against STIs and HIV/AIDS, mark "yes." If the provider does not mention this, mark "no."

B. Encourage use of condoms as 2nd method
A provider may or may not suggest that a client use condoms in addition to the method s/he has selected. If the provider does encourage the client to use condoms in addition to the method s/he is using, mark "yes." For example, a provider may say: "I know you are on the pill, but you may want to also use condoms to protect yourself from STIs and AIDS."

Clinical Observation (Females Only)

Mark only for those who received a pelvic exam, an IUD or an injectable.

INSTRUCTIONS TO OBSERVERS:
As a means of determining whether clinical procedures at this site are performed according to guidelines, this instrument addresses the provision of injectables, pelvic exams, and IUDs. You will observe as many clients as possible that undergo their procedures on the day of the observation at a given clinic. Mark for all of the sections that apply. For example, if a client receives an injectable and a pelvic exam, complete both sections of the observation guide.

40. Clinical provider same person who provided counseling
When the person who did the counseling is also doing the clinical exam, mark "Same person." This information will help link the observations of the two sections. If the provider or counselor is the same, go to item #43.

41. Provider performing MOST of the clinical examination:
Mark the type of provider that performed most of the clinical examination.

42. Sex of the Provider:
Mark whether the provider is female or male.

43. Observation conducted for:
Mark all sections "yes" or "no."

- Client received an injectable; if yes, complete section A.
- Client underwent a pelvic exam; if yes, complete section B.
- Client had an IUD inserted; if yes, complete section C.

This section is meant to ensure that the appropriate sections are completed or skipped depending on the clinical services received.

For each item below, mark "yes," "no," or "N/A" (not applicable) as appropriate.

A. Injectables
Note: Unless otherwise specified, the below information refers to Depo Provera®, one brand of injectable.

Did the Provider:
D-1. *(NEW CLIENT)* Reconfirm client's method choice
A provider may reconfirm the client's method choice by asking her if she is sure that she would like to use an injectable.

D-2. *(NEW CLIENT)* Verify client is not pregnant
The correct time to administer an injectable contraceptive is when the provider is confident that the client is not pregnant. This can be ensured by:

- providing the first injection during menstruation (5-7 days);
- ascertaining whether the client has had intercourse since the last normal menstrual period;
- asking if the client has been correctly and consistently using another reliable contraceptive method;
- ascertaining if the client is within 4 weeks postpartum (for non-lactating women), or fully breastfeeding and ammenorrheic and within first 6 months postpartum;
- determining if client is within 7 days post-abortion; or
- determining that a urine pregnancy test is negative and that the client has not had intercourse in the past two weeks.

Note: A negative response to the question "Are you pregnant?" is not sufficient. If this is the only means of ensuring that the client is not pregnant, the observer should mark "no," because the provider cannot be confident that the client is not pregnant.

D-3. *(CONTINUING CLIENT)* Give injection at correct time
The "correct time" varies by brand of injectable. The "correct time" for continuing clients is as follows:

- Depo Provera ® – 90 days after previous injection plus or minus 14 days
- NET EN (Noristerat®) – 60 days after previous injection plus or minus 7 days
- Monthly injections (e.g. Cyclofem ™, Cyclopprovera™, and Mesigyna®) - 30 days after previous injection plus or minus 3 days

Correct time can be determined by reviewing the client's appointment card, clinic record, or if the client history reveals the appropriate date.

D-4. Wash hands before injections
Did the provider use sterile hand washing techniques which include using soap or disinfectant, drying hands with a sterile towel, and not touching furniture or doors before gloving hands.

D-5. *(If re-usable)* Use newly reprocessed needle and syringe
Reusable needles or syringes should be used only once and then set aside for reprocessing after a single use. Providers are expected to use a newly reprocessed needle and syringe for each client in accordance with infection control procedures contained within the clinic guidelines. This is determined by the source of the needle/syringe. Removal from an autoclave, sterilizing solution or other sterilizing techniques defines an observed use of reprocessed needle/syringe.

D-6. Stir/mix bottle before drawing dose
A thoroughly mixed solution is important to assure that the full dose is given. The "yes" box should be marked if the vial is shaken or rolled between the palms.

D-7. Clean and air-dry injection site before injection
Cleaning the site of the injection with antiseptic prevents infection. Air-drying allows the antiseptic to have its full effect. Providers are expected to swab down the site with an antiseptic wipe and allow the site to dry before giving the injection. Failure to do either means the procedure was not properly followed and "no" should be marked.

D-8. *(If gluteal)* Inject in upper outer quadrant
The injectable contraceptive should be given in either one of two muscles: the deltoid muscle or the upper outer quadrant of the gluteal muscle. If the client receives the injection in the deltoid muscle, mark as not appropriate ("N/A"). If the client receives the injection in the gluteal muscle, mark "yes" if the injection site is the upper outer quadrant. Mark "no" if the injection site is not in the upper outer quadrant.

D-9. Draw back plunger before injection
To assure that the dose is given in the muscle and not in a blood vessel the provider should draw back on the plunger prior to injecting the medication to make sure no blood is seen in the syringe. If blood is seen, the provider should reposition the needle slightly without withdrawing it and again draw back the plunger to verify lack of blood. The answer to this question is "yes" if the provider performs this step just prior to depressing the plunger to disperse the medication.

D-10. Allow dose to self-disperse instead of massaging
After administering the injectable contraceptive, the injection should NOT be massaged. Massaging decreases the efficacy of the medication. The injectable contraceptive should be allowed to self-disperse. Note that many clinicians will wipe the site with the antiseptic wipe. This is not considered to be massaging the site unless pressure is used and wiping is extensive.

D-11. Dispose of sharps in puncture resistant containers
All needles and syringes should be placed in a puncture proof container *immediately* after use, without detaching the needle from the syringe. The needles should not be carried elsewhere for disposal. If the needle is put in a safe container immediately, mark "yes."

For each item below, mark "yes," "no," or "N/A" (not applicable) as appropriate.

B. Pelvic Exams

Did the provider:

P-1. Ensure client has privacy
Privacy during examinations is an important component of respecting the client's sense of modesty. Determine if clients or staff (other than those caring for the client) can hear or see the client. Check to see if the client is behind a screen or in a room such that only those people directly caring for her can hear or see her. Her privacy is ensured if the provider speaks in low tones, if there are no extra staff in the room, and if the session is not interrupted.

P-2. Prepare all instruments before exam
Being properly prepared before proceeding is important to ensure that the procedure can be carried out safely, efficiently, and with respect for the client. When the exam starts, all the equipment including a tenaculum, speculum, lights, antiseptic wipes, etc., should be within easy reach of the provider. If the provider must leave the client to get an instrument or supplies, mark "no."

P-3. Wash hands before exam
Did the provider use sterile hand washing techniques which include using soap or disinfectant, drying hands with a sterile towel, and not touching furniture or doors before gloving hands.

P-4. Use sterilized or high-level disinfected instruments for each exam
The observer should be able to tell if the equipment used in the exam is sterile. The equipment should have gone through a high-level disinfectant solution or been sterilized with steam, boiling, or dry heat. In some cases the sterilization process may not be observable because it takes place in a different part of the clinic or at another time. If this is the case, the observer should note if clinic staff handles the equipment in a sterile manner. Staff should

- store it properly,
- handle it only while wearing gloves,
- refrain from retrieving items from storage container after their hands are contaminated, and
- prevent sterile equipment from coming in contact with non-sterile surfaces (tables, etc.).

The observer must judge the sterility of the equipment, and, if either the sterilization process or the subsequent handling of the equipment is not consistent with sterile procedures, the observer must mark the "no" box.

P-5. Put on new or disinfected gloves before exam
All pelvic exams should be done using gloves on both hands. The provider has failed to follow standard infection prevention procedures, and "no" should be marked, if

- gloves are used for more than one exam without sterilization,
- the provider touches non-sterile instruments or surfaces, or
- the provider puts the gloves on in a way that contaminates the surface.

P-6. Inspect the external genitalia
The purpose of the exam is to determine whether there are signs of infection or abnormality. In observing the exam of external genitalia, the provider should do the exam before inserting a speculum and manipulate the genitalia to ensure exposure of all surfaces. The exam is usually very quick, thus the observer should be in position to see these activities. Also, there should be sufficient light to make a visual exam. If these conditions are not met or the observer is not sure of their being met, mark "no."

P-7. Ask the client to take slow, deep breaths, and to relax all muscles
To meet this requirement, the provider must specifically tell the client to breath deeply and relax all muscles. Only if the provider requests both actions of the client should "yes" be marked.

P-8. *(If used)* Explain speculum insertion procedure to client
The provider should explain the process of speculum insertion either before or during the actual placement. The kinds of phrases that would define an explanation to the client include

- "I am going to put this in you so I can see better."
- "This may be a little cold at first."
- "This should not hurt."
- "If you feel any pain, please tell me."
- "This will only take a minute or two."
- "Don't worry."

The provider may explain more to new, younger, or nulliparous clients. They do not have to explain everything; however, the observer should believe that the provider has explained enough to reduce the client's anxiety.

P-9. Inspect the cervix and vaginal mucosa
The vagina and cervix must be examined to look for evidence of infection, tears, growths or other abnormalities, or to evaluate complaints of vaginal discharge. For IUD insertion, this process is important to rule out conditions considered to be contraindications such as purulent cervicitis. The observer should consider the exam to be done properly if the provider looks closely at the cervix and has sufficient, direct light.

P-10. Perform the bimanual exam gently and without discomfort to the client
A provider performs this action correctly if he/she explains to the client what is happening and speaks calmly when asking her to relax her muscles. The provider should ask the client if she is experiencing any discomfort during the examination. The bimanual exam is done by inserting two fingers in the vagina while pressing the other hand on the abdomen. The observer must determine if it is done gently in order to avoid discomfort. While there will be some discomfort, especially if there is any pelvic inflammation, the provider should be as delicate as possible while performing the exam.

P-11. Ensure that instruments and reusable gloves are decontaminated
All contaminated instruments and supplies should be put into a decontamination solution immediately after the exam. They should not be carried to another site in the facility. If the exam area does not have a container of decontamination solution or the provider does not use it, mark "no." Note that some facilities may have sterilization facilities, like an autoclave, in the exam area. Putting equipment there directly is an acceptable alternative for decontamination.

For each item below, mark "yes," "no," or "N/A" (not applicable) as appropriate.

C. IUD Insertion

Did the Provider:

I-1. Ensure client has privacy
Privacy during examinations is an important component of respecting the client's sense of modesty. Determine if clients or staff (other than those caring for the client) can hear or see the client. Check to see if the client is behind a screen or in a room such that only those people directly caring for her can hear or see her. Her privacy is ensured if the provider speaks in low tones, if there are no extra staff in the room, and if the session is not interrupted

I-2. *(NEW CLIENT)* Reconfirm client's method choice
A provider may reconfirm the client's method choice **by asking her if she is sure that she would like to have an IUD inserted.**

I-3. Use sterilized or high-level disinfected instruments
The observer should be able to tell if the equipment used in the exam is sterile. The equipment should have gone through a high-level disinfectant solution or been sterilized with steam, boiling, or dry heat. In some cases the sterilization process may not be observable because it takes place in a different part of the clinic or at another time. If this is the case, the observer should note if clinic staff handle equipment as sterile. They should

- store it properly,
- handle it only while wearing gloves,
- refrain from retrieving items from storage container after their hands are contaminated, and
- prevent sterile equipment from coming in contact with non-sterile surfaces (tables, etc.).

The observer must judge the sterility of the equipment and if either the sterilization process or the subsequent handling of the equipment is not consistent with sterile procedures, the observer must mark the "no" box.

I-4. Wash hands before putting on gloves
Did the provider use sterile hand washing techniques which include: using soap or disinfectant, drying hands with a sterile towel, and not touching furniture or doors before gloving hands.

I-5. Glove hands
All IUD insertions should be done using gloves on both hands. The provider has failed to follow standard infection prevention procedures, and "no" should be marked, if

- gloves are used for more than one insertion without sterilization,
- the provider touches non-sterile instruments or surfaces,
- the provider puts the gloves on in a way that contaminates the surface.

I-6. Conduct speculum exam to check for signs of RTI/STIs[17]
The proper procedure for inserting an IUD is to first do a visual exam using a speculum and a light. If the provider performs this action, mark "yes."

I-7. Conduct bimanual pelvic exam
This action is performed correctly if the provider explains to the client what is happening and speaks to her calmly when asking her to relax her muscles. The provider should ask the client if she is experiencing any discomfort during the examination. The bimanual exam is done by inserting two fingers in the vagina while pressing the other hand on the abdomen. The observer must determine if it is done gently in order to avoid discomfort. While there will be some discomfort, especially if there is any pelvic inflammation, the provider should be as delicate as possible while performing the exam.

[17] Note: In programs where there is high compliance on both I-6 and I-7 it is possible to add another item to address the importance of the sequence of these actions which are: If there are no visual signs of RTI/STIs, the speculum is removed and a bimanual exam is done. If there is still no indication of RTI/ STIs, the speculum is reinserted, the IUD kit is opened, and insertion is completed.

I-8. Visualize cervix during cleaning
In order for the provider to properly visualize the cervix, she/he must insert a speculum and have a light source focused on the vaginal opening. This will allow the provider to adequately observe the cervix and surrounding tissue. The observer must judge whether the provider can see the vaginal tract and the cervix sufficiently to insert the IUD.

I-9. Use tenaculum
The tenaculum is used to stabilize the uterus and to minimize the risk of perforation. If a tenaculum is used, mark "yes."

I-10. Sound the uterus before IUD insertion
Sounding confirms the position of the uterus and the depth of the uterine cavity. The provider should insert the uterine sound with the speculum in place. The observer should mark "yes" if a sound is used prior to the IUD insertion.

I-11. Use the no-touch technique for inserting the IUD
The loaded IUD should not be passed through the cervix more than once to minimize the chance of infection.

I-12. Wash hands after removing gloves
Did the provider use sterile hand washing techniques that include using soap or disinfectant and drying hands with a sterile towel.

I-13. Ask client to wait/rest for at least 15 minutes after insertion
The provider should hold the client to observe for excessive cramping, nausea or fainting. The client should be given instructions to wait in the facility for 15 minutes (in the exam or waiting area) and told to alert the provider if she has any problems before she leaves the facility.

I-14. Wipe contaminated surfaces with disinfectant
If the provider has used a disinfectant to clean the surfaces, mark "yes." If the provider wipes the surfaces clean but does not use a disinfectant, mark "no." In some facilities, staff (other than the providers) do the post-exam decontamination. Observers should note whether decontamination is done before another client uses the examination room.

I-15. Ensure that instruments and reusable gloves are decontaminated
This can be determined by observing whether the provider immediately places instruments after use in a disinfectant solution to soak for 10 minutes. Ask the provider what the solution is. If it is not a disinfectant solution, mark "no."

Time observed session ended:
Write down the exact time that the observation ended using a 24-hour clock (military time). For example, 9:00 AM is recorded as 09:00, and 9:00PM is recorded as 21:00. Record the hours in the first two boxes, and record the minutes in the second two boxes.

Module 5:

Client Exit Interviews

- Tool
- Guidelines

Overview

The client exit interview collects information about the client's experience at a given health facility. It provides information about the following: (1) how well the client understood the information provided, (2) whether the client was given sufficient information to make an informed choice, (3) how the client felt about the services received, (4) how the client felt s/he was treated by the provider and the rest of the clinic staff, and (5) to what degree s/he felt involved in making a decision about contraceptive use. This instrument is important because it provides information about the quality of services received from the client's perspective.

Tips for Interviewers[18]

Building Rapport

At the beginning of the interview, you and the respondent are strangers to one another. It is important that you introduce yourself in a friendly manner, since the respondent's initial impression of you will influence his/her willingness to participate.

Make a good first impression

When you first meet with the respondent, try your best to make him/her feel at ease. Choose your words carefully and try to put the respondent in a positive frame of mind for the interview. Be sure to smile and introduce yourself and explain the study being conducted. An example of a good introduction is provided below:

"Good afternoon. My name is _____. I am a representative of [name of your organization]. We are conducting a survey about family planning [family life and health] services and are interviewing people throughout the country. I would like to talk with you and ask you some questions."

Always have a positive approach

Do not be apologetic when approaching respondents. For instance, do not say: "Are you too busy?", "Would you mind answering some questions?", or "Would you spare a few minutes?" These types of questions can lead to refusal from potential participants. Instead, *tell* the respondent, " I would like to ask you a few questions" or "I would like to talk with you for a few minutes."

Stress confidentiality of the responses to all clients

Assure all clients, especially those who are reluctant to participate, that the information is confidential. Explain that ***no*** individual names will be used for ***any*** purpose since each client will be assigned a number, not a name. In addition, information about respondents will be reported as a group.

Answer any questions from the respondent frankly

Prior to the interview, the respondent may have some questions for you about the survey. Answer his/her questions in an honest and pleasant manner. If s/he has specific questions about family planning methods or medical information, tell the respondent you will direct him/her to a nurse who can answer his/her questions after the interview.

The respondent may be concerned about the length of the interview. Tell the client the exit interview takes approximately 15 minutes, and stress to him/her the importance of participating in the survey.

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[18] These tips are largely drawn from: 1) *Interviewer's Manual: For use with Model 'A' Questionnaire for High Prevalence Countries,* (Macro International, 1997); and 2) *The Situation Analysis Approach to Assessing Family Planning and Reproductive Health Services: A Handbook* (Miller et al., 1997).

Interview the respondent alone
The presence of a third person can prevent the respondent from being open and honest. It is extremely important that the interview be conducted in a private area where s/he cannot be seen or heard.

If it is not possible to have privacy, you may have to carry out the interview in the presence of other people. In this case, you should try to separate yourself and the respondent as much as you can from other people.

Conducting the Interview

Be neutral throughout the interview
In an interview, people are usually polite and try to tell you what they think you want to hear. As a result, it is important that you remain neutral while you ask the questions. Do not allow the respondent (through your facial expression or your tone of voice) to think that s/he has given you the "right" or the "wrong" answer. Never approve or disapprove of any of the respondent's answers.

During the interview, a respondent may ask you your opinions about family planning. Focus the interview on the respondent's opinions and explain that telling him/her your opinions would slow down the interview process.

In the questionnaire, questions are worded in a neutral manner. Be sure to ask the complete question to ensure neutrality. If the respondent gives an unclear answer, try using the following probes:

- "Can you explain a little more."
- "I did not hear you, could you please explain again."
- "There is no hurry. Take a moment and think about it."

Never suggest answers to the respondent
If a respondent gives an answer that is not relevant to the question asked, **do not** prompt him/her by saying "So you mean . . . right?" Oftentimes, the respondent will agree with your answer, even if that is not what s/he originally meant. Instead, try to probe in such a way that the respondent comes up with the answer himself/herself. Never read off the list of coded responses to the respondent unless the instructions indicate to do so.

Do not change the wording or the sequence of the question
The wording and the sequence of the questions in the questionnaire must not be changed. If a respondent does not understand a question, simply repeat it again slowly and clearly. If s/he still does not understand the question, you may then reword the question as long as you are careful not to change the original meaning of the question. However, provide only the minimum amount of information necessary to obtain an answer to the question.

Handle hesitant respondents tactfully

There may be situations where the respondent loses interest in the interview. The respondent may say "I don't know," give answers that are not relevant, act bored, contradict something s/he has already said, or refuse to answer the question. In this instance, you must find a way to re-engage the respondent in the interview. Take a few minutes to talk about something else that is not related to the interview such as the weather, his/her town, daily activities, etc.

If a respondent gives irrelevant or very wordy answers, listen to what s/he says. Do not interrupt him/her abruptly. Gently, try to steer the respondent back to the interview questions. It is extremely important that you maintain a friendly atmosphere. The respondent should not feel intimidated. S/he should feel as though the interviewer is sympathetic and someone to whom s/he could say anything and not feel shy or embarrassed.

If the respondent remains reluctant to answer, explain that the same questions are being asked of people all over the country at different family planning clinics. All of the answers from the surveys will be grouped together and a client number, **not** a name, will be associated with his/her responses. If s/he still refuses to answer, mark the appropriate spot on the questionnaire. **Remember:** A respondent cannot be forced to answer a question.

Do not form expectations

Do not form expectations about the ability and the knowledge of the respondent. For example, do not assume that people from rural areas are less educated, illiterate and know nothing about family planning.

It is also important to acknowledge that there may be differences between you and the person that you are interviewing. The respondent may feel that you are different than s/he is and as a result be mistrustful of you. Try your best to make him/her feel at ease so that s/he is comfortable talking with you. Interviewers should be matched by sex with the client, in that female respondents would have female interviewers and male respondents would have male interviewers.

Do not hurry the interview

Ask questions slowly and clearly to ensure that the respondent understands the question being asked. Be sure to give him/her plenty of time to answer. If a respondent feels rushed, s/he may not take time to fully think through his/her answers, or s/he may answer "I don't know." If you feel that the respondent is not fully thinking through his/her answers, remind the respondent that there is no hurry and that s/he should take his/her time to consider his/her opinion.

Identification number : ☐☐ ☐☐ ☐☐ ☐☐
Region District Facility Client

Client Exit Interview

CLIENT NUMBER: ☐☐
IMPORTANT: Assign the same client number on this form as was assigned to the observation.

Interviewer (Name & Number): _____ ☐☐

BACKGROUND CHARACTERISTICS

01 **Health Facility (Name & Number):** _____ ☐☐

02 **District (Name & Number):** _____ ☐☐

03 **Region (Name & Number):** _____ ☐☐

04 **Date of interview:** ☐☐ ☐☐ ☐☐
Day **Month** **Year**

05 **Type of Facility Where Interview Took Place**

- ☐ 1. Referral Hospital
- ☐ 2. District Level Hospital
- ☐ 3. Family Planning Clinic
- ☐ 4. Health Center
- ☐ 5. Health Post
- ☐ 6. Mobile Health Clinic
- ☐ 7. Clinics in non-permanent facilities (schools, rotating rural health outposts, etc.)
- ☐ 8. Other _____

06 **Type of Sector**

- ☐ 1. Government/Ministry of Health
- ☐ 2. Government/Other
- ☐ 3. FP Association (IPPF affiliate)
- ☐ 4. Other NGOs
- ☐ 5. Missionary
- ☐ 6. Private
- ☐ 7. Other

07 **Locality of Facility**

- ☐ 1. Rural
- ☐ 2. Urban
- ☐ 3. Peri-urban

INSTRUCTIONS TO INTERVIEWER: When a family planning client has finished his/her consultation with the clinic staff, ask him/her if s/he is willing to answer a few questions about the service received. It is essential that you gain informed consent before beginning the interview, so the following introduction, or an alternate one designed by a research organization in your country, should be given.

GREETING/ VERBAL CONSENT FORM
Good morning/afternoon. My name is _____.

Thank you for taking the time to talk with me. (*Name of organization conducting the study*) is asking questions of men & women such as yourself throughout the country. We are studying quality of family planning services and ways to improve quality. This clinic has been chosen to be included in the study. If you agree to be interviewed, I will be asking you questions about yourself and your ideas, attitudes, and behavior on various issues. We are interested in finding out what people think about the family planning services that they have received. This information will be used to help develop better health services in our country.

If you decide that you do not want to participate in the study, or decide at any time in the future that you do not want to participate, it will not affect the services you receive at the clinic now or in the future. While the results of this study may be published, your privacy will be protected and you will not be identified in any way. No one, including your (*doctor/nurse/nurse-midwife*), will know your answers.

Your opinions and experiences are important to us, so please be honest and truthful in answering our questions. Your answers will be confidential and secret. If you agree to be interviewed, we will go to a place where no one can hear us talking. Some of the questions I will ask you are personal. If you are uncomfortable with a question, you do not have to answer it if you do not want. You may also stop the interview at any time.

It will take about 15 minutes for us to complete the questionnaire. Do you have any questions about the study? If you have any questions about the study in the future please feel free to contact (*name of organization conducting the study*).

_____ _____
Signature of Person Administering Consent Date

If client refuses to be interviewed, please check this box: ☐

Time Interview Began: ☐☐ : ☐☐
(use military time) **Hours** **Minutes**

No	QUESTION	RESPONSE		GO TO
100	Have you ever visited this site for family planning services before today?	Yes	1	
		No	2	
101	What was the reason for your visit today? *Probe until you are able to classify the main reason for the client's visit.*	**Get information and/or counseling** about a contraceptive method.....	1	
		Receive, get prescribed or referred for a contraceptive method for the first time or for the first time at this site	2	108
		Restart contraceptive method use (after not using for 6 months or more).....	3	
		Get supplies for method already using or have a routine follow-up visit for method already using.....	4	
		Restart same method (after not using for *less than six months*)	5	
		Switch contraceptive methods **or restart a different method** (after not using *for less than 6 months*)	6	102
		Discuss a problem about contraceptive method that you are currently using	7	
		Other, non-family planning.....	8 →	118
102	What contraceptive method are you using/were you last using (in the past 6 months)?	Pill	1	
		IUD	2	
		Injectable	3	
		Implant.....	4	
		Female Sterilization	5	
		Vasectomy.....	6	
		Condom.....	7	
		Spermicide	8	
		Rhythm/Periodic Abstinence	9	
		LAM	10	
		Diaphragm	11	
		Condom + other method _____	12	
		Other_____	13	
103	Did the provider ask if you were having a problem with the method (**Probe:** or did you mention a problem)?	Yes	1	
		No	2	
104	Have you had a problem with your method (**Probe:** that you wanted to discuss with your provider)?	Yes	1	
		No	2 →	108

No	QUESTION	RESPONSE	GO TO
105	Did the provider try to understand the nature of your problem?	Yes ..... 1 No 2	
106	Did the provider suggest what you should do (action you should take) to resolve the problem?	Yes ..... 1 No 2	
107	Were you satisfied with the advice or treatment that you received for your problem?	Yes ..... 1 No 2	
108	Did you come here today to obtain a specific contraceptive method?	Yes ..... 1 No ..... 2 →	110
109	Which method did you want when you came here? (**PROBE**: Before your consultation, did you have a specific method in mind?)	Pill ..... 1 IUD ..... 2 Injectable ..... 3 Implant..... 4 Female Sterilization ..... 5 Vasectomy..... 6 Condom..... 7 Spermicide ..... 8 Rhythm / Periodic Abstinence ..... 9 LAM ..... 10 Diaphragm ..... 11 Condom + other method ..... 12 Other_____ 13	
110	Which methods did the provider discuss with you?	Yes No A. Pill..... 1 2 B. IUD ..... 1 2 C. Injectable..... 1 2 D. Implant..... 1 2 E. Female Sterilization ..... 1 2 F. Vasectomy..... 1 2 G. Condom ..... 1 2 H. Spermicide ..... 1 2 I. Periodic Abstinence/ Rhythm ..... 1 2 J. Breastfeeding/LAM ..... 1 2 K. Diaphragm ..... 1 2 L. Condom + other method ..... 1 2 M Other _____ N. Don't know..... 8	
111	Did you receive a contraceptive method today?	Yes..... 1 → No..... 2	113

No	QUESTION	RESPONSE	GO TO
112	Were you given a prescription or a referral for a method today?	Yes, prescribed a method……..…. 1 Yes, referred for a method …… 2 No (but a method was named in 109)…... 3 → 114 No (no method was named in 109)……... 4 → 118	
113	Which method(s) did you receive or were you given a prescription or a referral? (**PROBE**: Any others?) *Mark all that apply.*	Yes No A. Pill ..... 1 2 B. IUD..... 1 2 C. Injectable (i.e., Depo Provera) ..... 1 2 D. Implant ..... 1 2 E. Female Sterilization ..... 1 2 F. Vasectomy ……1 2 G. Condom..... 1 2 H. Spermicide ..... 1 2 I. Periodic Abstinence/ Rhythm ..... 1 2 J. Breastfeeding/LAM..... 1 2 K. Diaphragm..... 1 2 L. Condom + other method..... 1 2 M. Other _____ 1 2	
114	*To be answered by the interviewer.* *Did the client receive his/her method of choice?* (Check questions #109 and #113.) *Is the method named in #109 and #113 the same?*	*Yes (client did receive method of choice)*..... 1 *Client had no preference* ……..... 2 No (client did not receive method of choice..... 3 → 115	*116*
115	Why do you think you did not get (**method named in 109**)? *Mark most important reason only.* Other response: _____ _____ _____	Chose not to accept a method at this time.. 1 → 118 Preferred method was not appropriate (contraindications)..... 2 Provider recommended another method... 3 Changed mind after listening to provider.. 4 Not available at clinic today..... 5 Not available at all..... 6 Not available, referred to another source... 7 No appropriate provider available that day ..... 8 Other (**specify to left**)..……..... 9 Don't know/ can't remember...…….. 88	

Note: If more than one method received/ prescribed/ referred for, only mark #116 and #117 for the MOST EFFECTIVE method (see guidelines). If NO method is received/ prescribed/ referred, go to #118.

No	QUESTION		RESPONSE	GO TO
116	For the method you just decided to accept, did the provider: **A.** Explain to you how to use the method effectively? *Do not ask if method = sterilization*		Yes ..... 1 No ..... 2 Don't know/ can't remember..... 8 Not applicable *(method = sterilization)*.. 9	
	B. Describe possible side effects?		Yes ..... 1 No ..... 2 Don't know/ can't remember..... 8	
	C. Tell you what to do if you have any problems?		Yes ..... 1 No ..... 2 Don't know/ can't remember..... 8	
	D. Explain that this method does not provide protection against STIs and AIDS? *Do not ask if method = condoms*		Yes ..... 1 No ..... 2 Don't know/ can't remember..... 8 Not applicable *(method = condoms)*..... 9	
117	⇨ ***Circle the method(s) received/ prescribed/ referred in #113 and ask the question(s) that correspond to the method(s).***			
	A. Pill	How often do you take the pill?	Take the pill once a day ..... 1 Other ..... 2 Don't know 8	
	B. IUD	What should you do to make sure that your IUD is in place?	Check strings..... 1 Other ..... 2 Don't know 8	
	C. Injectable, (e.g., Depo Provera)	How long does the injection provide protection against pregnancy?	3 months ..... 1 Other ..... 2 Don't know 8	
	D. Implant	How long does an implant provide protection against pregnancy?	5 years ..... 1 Other ..... 2 Don't know 8	
	E. Female Sterilization	Once you have been sterilized, could you ever become pregnant again?	No ..... 1 Other ..... 2 Don't know..... 8	
	F. Vasectomy	Once you have been sterilized, can you ever impregnate a woman again?	No ..... 1 Other ..... 2 Don't know..... 8	
	G. Condom (male or female)	How many times can you use a condom?	Once ..... 1 Other ..... 2 Don't know 8	

No	QUESTION		RESPONSE	GO TO
(117)	**H.** Spermicide	Approximately how long before intercourse should you insert the vaginal tablet?	Between 15 minutes and 1 hour ..... 1 Other ..... 2 Don't know 8	
	I. Periodic Abstinence/ Rhythm	How do you recognize the days on which you should <u>not</u> have sexual intercourse?	Body temperature rises..... 1 Mucus in vagina ..... 2 Days 12 – 16 of the menstrual cycle..... 3 Other ..... 4 Don't know 8	
	J. LAM	Can you use this method if your menstrual period has returned?	Yes ..... 1 No ..... 2 Don't know 8	
	K. Diaphragm	Approximately how long after intercourse should the diaphragm remain in place?	At least six hours (but no longer than 24 hours) ..... 1 Other ..... 2 Don't know 8	
118	Were you told when to return for a follow-up visit?		Yes ..... 1 No ..... 2 Don't know/ can't remember..... 8	
119	Did you feel comfortable to ask questions during the session?		Yes ..... 1 No ..... 2 Don't know..... 8	
120	Do you feel the information given to you during your visit today was too little, too much, or just about right?		Too little..... 1 Too much ..... 2 About right ..... 3 Don't know..... 8	
121	Did you have a pelvic exam during your visit today? (females only)		Yes ..... 1 No ..... 2 →	123
122	Did you have enough privacy during your exam? (**Probe**: Clients or staff, other than those caring for you, could not see you.)		Yes ..... 1 No ..... 2 Don't know/ can't remember..... 8	
123	When meeting with the provider during your visit, do you think other clients could hear what you said? (**Note**: This does not include the outside observer.)		Yes ..... 1 No ..... 2 Don't know..... 8	
124	Do you believe that the information that you shared about yourself with the provider will be kept confidential?		Yes ..... 1 No ..... 2 Don't know..... 8	
125	During your visit to the clinic how were you treated by the provider?		Very well..... 1 Well..... 2 Not very well/ poorly 3	

No	QUESTION	RESPONSE		GO TO
126	During your visit to the clinic how were you treated by the other staff?	Very well Well Not very well/ poorly There was no other staff	1 2 3 4	
127	About how long did you wait between the time you first arrived at this clinic and the time you saw a staff person for a family planning consultation?	<15 minutes 16-30 minutes 31-45 minutes 46-60 minutes 61-90 minutes 91-120 minutes >120 minutes Don't know	1 2 3 4 5 6 7 8	
128	Do you feel that your waiting time was reasonable or too long?	No waiting time Reasonable/ short Too long Don't know	1 2 3 8	
129	During your talk with the provider was STIs/AIDS discussed?	Yes No Don't know/ can't remember	1 2 8	
130	*Do not ask if method = condoms* Did the provider encourage you to use condoms at the same time (**Probe:** simultaneously) as the family planning method you chose or are currently using?	Yes No Don't know/ can't remember Not applicable *(method = condoms)*	1 2 8 9	
131	How many living children of your own do you have? *(Record number given)*	Number of children None Don't know	□□ 0 8	
132	Would you like to have (a/another) child in the future?	Yes No Depends on husband Depends on god Don't know	1 2 3 4 8	→ 134
133	How long would you like to wait from now before the birth of (a/another) child?	Less than a year One to two years More than two years Don't know	1 2 3 8	

No	QUESTION	RESPONSE	GO TO
134	Did you and the provider talk about whether or not you would like children in the future?	Yes..... 1 No..... 2 Don't know..... 8	
135	How old were you at your last birthday?	(Exact age) ..... ☐☐ Don't know..... 8	
136	Have you ever attended school?	Yes..... 1 No ..... 2 →	139
137	What is the highest level of school that you attended? (Probe: Did you attend primary, secondary, or higher?)	Primary..... 1 Secondary ..... 2 Higher 3	
138	What is the highest grade/ form/ year you completed at that level?	Grade ..... ☐☐	
139	Before we finish, I'd like to ask you some questions about yourself and your household. Could you describe the main material of the floor of your home?	Natural floor (Earth/sand/dung)..... 1 Rudimentary floor (Wood planks, palm/bamboo)..... 2 Finished floor (Polished wood, vinyl, ceramic tiles, cement, marble)..... 3 Other _____ 4 (specify) Don't know 8	

No	QUESTION	RESPONSE	GO TO
140	What is your main source of drinking water?	Piped water Piped into dwelling ..... 11 Piped into yard/plot..... 12 Public tap ..... 13 Well water Protected well ..... 21 Unprotected well..... 22 Surface water Developed spring ..... 31 Undeveloped spring ..... 32 River/ Stream ..... 33 Pond/ lake ..... 34 Dam ..... 35 Rainwater..... 41 Tanker Truck/Peddler..... 51 Bottled Water ..... 61 Other _____ 96 (specify) Don't know 88	
141	Do you or anyone in your household have … ? *(Mark all that apply)*	Yes No A. Bicycle .....1 2 B. Motorcycle.....1 2 C. Car.....1 2	
142	Does your household have . . .	Yes No A. Electricity?.....1 2 **B.** A radio/radio cassette?.....1 2 **C.** A television? .....1 2 **D.** A telephone/cellular telephone?....1 2 **E.** A refrigerator/freezer? 1 2	
143	Which language do you normally speak at home?	Language A ..... 1 Language B ..... 2 Language C ..... 3 Language D ..... 4 Other _____ 5 (specify)	

No	QUESTION	RESPONSE	GO TO
144	What is your ethnicity?	Ethnicity A.....…… 1 Ethnicity B .....…… 2 Ethnicity C .....…..... 3 Ethnicity D .....…… 4 Other _____ 5 (specify)	
145	What is your religion?	Religion A.....……. 1 Religion B .....……. 2 Religion C .....…….. 3 Religion D .....…… 4 Other _____ 5 (specify)	
146	What is your current marital status?	Married /monogamous …….. 1 Married /polygamous ……. 2 Cohabiting ……. 3 Single, never married ……. 4 Divorced / separated / widowed …… 5	
147	Sex of client	Female ……..... 1 Male…….. 2	

THANK THE RESPONDENT FOR HIS/HER TIME.

Time Interview Ended:
(use military time) ☐☐ : ☐☐

Hours **Minutes**

Cover pages

Most of the information on the two cover pages can be filled out before the interview begins. The first page asks for information about the types of facility, type of sector, and locality of the facility in addition to information about the district and region within which the facility is located.

Page two provides instructions for the interviewer and a greeting that you must read to the client in order to obtain consent. IMPORTANT: You must obtain consent from the client before you can start the interview. If the client refuses to participate in the study, mark that s/he has "refused." If the client agrees to participate in the interview, continue to the first question of the Client Exit Interview.

Note: Record both the hour and minute the interview began using a 24-hour clock (military time). For example, if the first patient arrived at 8:00 AM record 08:00. If the first patient arrived at 1:00 PM record 13:00.

Identification Number

Country Specific. The number of digits for the identification number is country specific. Some countries may not have both regions and districts. This number uniquely identifies each observation. The codes should be entered in the following sequence: region, district, facility, and then client. These numbers may be assigned specifically for this study or an existing ID number may be used.

Client Number

Record the number assigned to the client. This number identifies the client for both the clinical observation and the client exit interview. If more than one observation has taken place simultaneously, the observation ID numbers (and exit interviews) may not be sequential. Some countries may assign observation ID numbers after the clinical session in order to allow sequential numbering for the exit interview. In any case, the system should be determined by the principal investigator and used by all teams.

Interviewer (Name and Number)

Record the name and the assigned number of the interviewer conducting the interview here.

01. Health Facility (Name and Number)
02. District (Name and Number)
03. Region (Name and Number)

It is important that the correct numbers and names are recorded for the interview identification, health facility, district, region, and provider. The supervisor or the team leader should make sure that the correct numbers are recorded here.

04. Date of Interview

Record today's date here. Record the day first, then the month, followed by the year. For example, if the date is April 14, 2001 write: [1][4] [0][4] [0][1].

05. Type of Facility where the Interview Took Place

The type of facility refers to the services offered. The types will vary by country, but should reflect the actual structure of health facilities available in the country.

06. Type of Sector
Sector type describes the sponsoring agency for the facility. The types will vary by country. If there is any question about the type (e.g., multiple sources of financial staffing or commodity support) refer the selection to a supervisor.

07. Locality of Facility
Country specific. Mark the appropriate locality in which the facility operates. The locality is usually determined administratively. It may be necessary to ask or check with local officials. Urban clinics can appear to be in a rural area and be serving a rural population. Some countries may only denote "rural" and "urban" areas. Adapt the locality to reflect the situation in your country.

Question-by-question guide:

Instructions: Below in **boldface** type are the questions found in the Client Exit Interview. Instructions for the person conducting the exit interview appear *in italics*. These instructions are not to be read to the respondent. Before interviewing, be sure to be thoroughly familiar with this question-by-question guide, so that you understand what each question is asking.

100. Have you ever visited this site for family planning services before today?
We are interested in finding out if the client has EVER been to this site for family planning services in the past. If s/he has been to the site specifically for family planning services in the past, mark "yes." If s/he has NEVER been to the site specifically for FP services, mark "no." NOTE: If a woman has visited the site before, but only for an MCH visit, you should mark "no."

101. What was the reason for your visit today? ***(Probe until you are able to classify the main reason for the client's visit.)***
The main reasons a client may come to a family planning clinic are listed below. The Client Exit Interview is structured such that the client is asked specific questions depending upon the reason for the visit. Consequently, it is extremely important to accurately determine which category best describes the reason for the client's visit so that each client is asked questions that apply to his/her particular situation. If a client comes to

- **Get information and/or counseling** about a contraceptive method**,** go to #108;
- **Receive, get prescribed or referred for a contraceptive method** for the first time ever or for the first time at this site, go to #108;
- **Restart** contraceptive method use (after not using for 6 months or more), go to #108;
- **Get supplies** for a method you are already using or **have a routine follow-up** for method already using, go to #102;
- **Restart same method** (after not using for less than 6 months), go to #102;
- **Switch** contraceptive methods or **restart different method** (after not using for less than 6 months), go to #102;
- **Discuss a problem** with the contraceptive method that you are currently using, go to #102;
- **Other**, non-family planning, go to #118.

102. What contraceptive method are you using/were you last using (in the past 6 months)?
Write down the name of the contraceptive method that the client is currently using. If the client has recently (within the last 6 months) stopped using a contraceptive method due to a problem, mark the name of the last contraceptive method s/he used. If the client is using the condom in addition to another method, mark "condom + other" and record the name of the "other" method.

103. Did the provider ask if you were having a problem with the method (*Probe: or did you mention a problem)?*
Determine if the provider and the client discussed any problem that the client is having with his/her contraceptive method. Mark "yes" if the client has discussed a problem (serious or minor) with his/her provider. If the provider did not ask if s/he is having a problem, mark "no."

104. Have you had a problem with your method *(Probe: that you wanted to discuss with your provider)?*
Find out if the client has had a problem that s/he wanted to discuss with the provider concerning the method that s/he is currently using. If the client has not had a problem with his/her contraceptive method, go to question #108.

105. Did the provider try to understand the nature of your problem?
Here we would like to know if the provider probed the client for more information about his/her problem. Find out if the provider asked about his/her medical history or about any potential contraindications that s/he may have.

106. Did the provider suggest what you should do (action you should take) to resolve the problem?
Find out if the provider gave the client information about what to do to resolve his/her problem. For example, the provider may have suggested that she change her brand of pill if she is experiencing problems with the brand she is currently using. If the client is allergic to spermicides, the provider may have suggested trying a different contraceptive method.

107. Were you satisfied with the advice or treatment that you received for your problem?
Here we are interested in the client's opinion. Clients who are satisfied with the services they receive may be more likely to continue to use contraception.

108. Did you come here today to obtain a specific contraceptive method?
If the client is here to obtain a specific family planning method, mark "yes" and continue to the next question. If the client is not at the clinic to obtain a particular contraceptive, mark "no" and go to question #110.

109. Which method did you want when you came here? *(PROBE: Before your consultation, did you have a specific method in mind?)*
Here we would like to know if the client wanted a specific method before s/he came into the clinic. Clients who have a preference for a method and who receive that method may be more likely to continue using it.

110. Which methods did the provider discuss with you?
Research indicates that it is important for providers to discuss a range of methods with clients to ensure "choice of methods." Clients who are offered a greater range of methods are more likely to be

satisfied. Additionally, family planning clients who do not receive their *preferred* method tend to have lower satisfaction and/or continuation rates, regardless of the effectiveness of the method. NOTE: Mark "yes" for all methods discussed and "no" for methods not discussed.

111. Did you receive a contraceptive method today?
We are interested in finding out which method the client actually received today. If the client received a method, mark "yes" and go to question #113. If s/he did not receive a method today, continue to question #112.

112. Were you given a prescription or a referral for a method today?
Mark if the client was prescribed or given a referral for a particular method today. If the client was not given a prescription or a referral and DID name a method in #109 (s/he does have a preference for a method), go to #114. If the client was not given a prescription or a referral and DID NOT name a method in #109 (s/he does not have preference for a method), go to question #118. Here, we are interested in finding out if those clients who **did not** receive a method were provided a means for obtaining the method in the near future.

113. Which method(s) did you receive or were given a prescription or a referral? (*PROBE: any others?)*
We would like to know which method(s) the client either received or for which s/he was given a referral or a prescription. Mark the method as appropriate. For example, if a woman received condoms today and was given a prescription for the pill, you should mark "yes" for condom and "yes" for the pill. If the client did not receive the method, mark "no."

114. To be answered by the interviewer. Did the client receive his/her method of choice?
If the method the client received or got a prescription or referral for in #113 is the same method mentioned in #109, go to #116. If the client had "no preference" (answered "no" to #108), go to #116. If the preferred method (#109) and method received, prescribed or referred for are not the same, continue to #115.

115. Why do you think you did not get (method named in 109)?
There are a number of reasons that the client may not have received his/her method of choice. We are interested in finding out why the client did not receive his/her preferred method. If the client's response is one of the categories on the questionnaire, mark the appropriate category. If the client's response does not correspond with any of the pre-defined categories, mark "other" and write down the response verbatim in the space provided. NOTE: If the client provides more than one response, ask him/her for the **most** important reason.

116. **Note:** If more than one method received, prescribed, or referred for, only mark for the most effective method. If no method received, prescribed, or referred for, go to #118. Methods from most to least effective (as commonly used) are: implant, vasectomy, injectables, female sterilization, IUD, LAM (for 6 months only), pill, male condom, diaphragm (with spermicide), rhythm and periodic abstinence, female condoms, and spermicide.[19]

[19] For more in-depth information users are referred to: *The Essentials of Contraceptive Technology: A Handbook for Clinic Staff* (Hatcher et al., 1998).

For the method you just decided to accept, did the provider:

A. **Explain to you how to use the method?** ***(Do not ask if method = sterilization)***
B. **Describe possible side effects?**
C. **Tell you what to do if you have any problems?** Research demonstrates that clients are more likely to continue to use a method if they are knowledgeable not only about how to use the method, but also about possible side effects or complications.
D. **Explain that this method does not provide protection against STIs and AIDS?** ***(Do not ask if method = condoms).*** Providers should explain if a method protects against STIs or HIV. If the client's method is condom, you do not need to ask this question because condoms do protect against HIV/STIs.

117. ***Circle the method(s) received, prescribed, or referred for in #113 and ask the question(s) that correspond to the method(s).***

A. Pill
B. IUD
C. Injectable (e.g., Depo Provera)
D. Implant
E. Female sterilization
F. Vasectomy
G. Condom (male/female)
H. Spermicide
I. Periodic abstinence/Rhythm
J. LAM
K. Diaphragm

First circle the contraceptive method(s) that the client has decided to use today or is currently using. Next, ask the client the question that corresponds with the contraceptive method that s/he has chosen or is currently using. Last, note answers to the question that corresponds with the contraceptive method. For example, if the client has decided to use an implant, ask her "How long does an implant protect against pregnancy?" Mark her answer as appropriate.

118. Were you told when to return for a follow-up visit?
Contraceptive users who are aware of when they should return for a follow-up visit may be more likely to continue to use contraception.

119. Did you feel comfortable to ask questions during the session?
Providers who encourage clients to ask questions may indicate a higher quality of service and could affect the client's continuity with the method.

120. Do you feel the information given to you during your visit today was too little, too much, or just about right?
This information may be used to ascertain what length of time is considered appropriate for most clients. In addition, it serves as an indirect measure of whether providers are tailoring their consultations to meet the particular needs of the specific client.

121. Did you have a pelvic exam during your visit today? (females only)
If the client had a pelvic exam, mark "yes." If the client marked "no" go to #123.

122. Did you have enough privacy during your examination? ***(PROBE: clients or staff, other than those caring for you, could not see you?)***
Mark the answer that best describes the client's opinion of whether on not s/he had enough privacy.

123. When meeting with the provider during your visit, do you think other clients could hear what you said? (This does not include the observer.)
Again, mark the appropriate response based on the client's opinion.

124. Do you believe that the information that you shared about yourself with the provider will be kept confidential?
Probe the client by asking if s/he thinks that the clinic staff will talk about the information that s/he disclosed outside of the clinic.

125. During your visit to the clinic how were you treated by the provider?
Probe to see if the client feels like s/he has been treated well. We are interested in the client's opinion of whether or not s/he has been treated well. Read the responses and mark as appropriate.

126. During your visit to the clinic how were you treated by the other staff?
Here we are interested in finding out about how the client feels about the rest of the staff. The rest of the staff refers to everyone working in the clinic with whom s/he has interacted with the exception of his/her provider. Again, we are interested in the client's opinion of whether s/he has been treated well or not. Read the responses and mark as appropriate.

127. About how long did you wait between the time you first arrived at this clinic and the time you saw the staff person for a family planning consultation?
We are interested in finding out how long the client had to wait for services. If the client does not know exactly how long s/he waited, encourage the client to try to estimate how long s/he waited. If necessary, probe by giving the client some potential 'markers' for his/her time. For example, a client may have arrived in the morning and been seen after lunch.

128. Do you feel that your waiting time was reasonable or too long?
This question is to determine if the amount of time that the client waited **before** s/he received the services was reasonable or too long.

129. During your talk with the provider was STIs/AIDS discussed?
Some ways to protect against STIs and AIDS are as follows: use a condom (male or female), practice monogamy, or abstain from sex (not likely to be mentioned if client is obtaining family planning). Even if the provider gave the client incorrect information, mark down the response that best reflects the client's opinion of whether or not this topic was discussed.

130. *(Do not ask if method = condoms)* **Did the provider encourage you to use condoms at the same time (Probe: simultaneously) as the family planning method you chose or are currently using?**
For clients who are at high risk for STIs and HIV/AIDS, providers may recommend that a client use condoms along with the contraceptive method that s/he decided to accept. Ask this question to all respondents that are not currently using condoms. NOTE: The question asks for use of condoms in addition to another contraceptive method.

131. How many children of your own do you have? ***(Record number given)***
Record the number of children that the client says s/he has. A client has children EVEN if they are not currently staying with him/her. Children that s/he is watching for someone else (e.g., his/her sister's children) are NOT considered his/her children.

132. Would you like to have (a/another) child in the future?
We are interested in finding out the client's reproductive intentions. This information may be used to assess if the client has received an appropriate method. It is important to note that a client may believe that s/he does not have control over whether or not s/he will have another child. The client may believe that God will decide if s/he will have a/another child, or a woman's husband may decide if they will have a/another child,. If the client answers "no," go to #134.

133. How long would you like to wait from now before the birth of (a/another) child?
This information is important because it may be used to determine if the client received an appropriate method. Some clients may want to delay or space their births. If the client has an opinion about when s/he would like to have another child, mark the appropriate time. Some clients may not have a specific time in mind. If a client is not sure when s/he would like his/her next child, mark "don't know."

134. Did you and the provider talk about whether or not you would like children in the future?
If the client states that s/he or the provider brought up the desire for more children, mark "yes." If the client does not feel that this subject was addressed during the consultation, mark "no."

135. How old were you at your last birthday?
Record the number of years that the client states. If s/he does not know his/her exact age, encourage the client to estimate his/her age. Assist the client by naming historical dates that may help determine age. NOTE: We are interested in how old the client was at his/her last birthday.

136. Have you ever attended school?
We are interested in whether or not the respondent has attended school. If s/he answers "no," skip to question #139.

137. What is the highest level of school that you attended? ***(PROBE: Did you attend primary, secondary, or higher?)***
We are interested in the highest level of school that the respondent attended. For example, a client may have completed two years of primary school. On the questionnaire, mark the level (primary) to indicate that the highest level s/he attended was primary school.

138. What is the highest grade/ form/ year that you completed at that level?
Record the highest grade/ form/ year completed in primary, secondary or higher. As in the previous example, if the client attended primary school and completed the second form, write | 0 | 2 |.

139. Before we finish, I would like to ask you some questions about yourself and your household. Could you describe the main material of the floor of your home?
Clients may have different kinds of material on the floors of their homes. If a client has trouble answering this question, ask the client to tell you what his/her floor looks like.

140. What is your main source of drinking water?
Clients may have different sources of drinking water. If the client has problems identifying his/her source of drinking water, read off the responses and mark as appropriate.

141. Do you or anyone in your household have . . .?
Read the list and mark "yes" for all of the items that the client owns. Clients may own more than one of these items. If the client owns more than one item, mark "yes" for all of the items that s/he owns. If the client has none of the items on the list, mark "no" for each item.

142. Does your household have ... ?
Read the list and mark "yes" for all of the items that the client's household has. Clients may own more than one of these items. If the client owns more than one item, mark "yes" for all of the items that s/he owns. If the client has none of the items on the list, mark "no" for each item.

143. What language do you normally speak at home?
Country-specific. The Client Exit Interview should be adapted to reflect the languages spoken in your country. We are interested in the language that is spoken the most at home. The language spoken at home may be different than the language the client speaks in public settings.

144. What is your ethnicity?
Country-specific. The Client Exit Interview should be adapted to reflect the different ethnic groups in your country. We are interested in the ethnic group to which the client belongs.

145. What is your religion?
Country-specific. The Client Exit Interview should be adapted to reflect the different religions in your country. We are interested in the religious group to which the client belongs.

146. What is your current marital status?
Note that we are interested in the client's current marital status. If s/he is married, and only with one partner, mark "married/monogamous." If s/he is married and it is a polygamous union, mark "married/polygamous." If s/he is living with someone and is not married, mark "cohabiting." If the respondent is single and has NEVER been married, mark "single, never married." Lastly, if a respondent has been married but is divorced, separated or widowed, mark "divorced/ separated/ widowed."

147. Sex of Client
Mark whether the client is female or male.

THANK THE RESPONDENT FOR HIS/HER TIME.

Time interview ended: Note the time that the interview ended. Record both the hour and minutes the interview ended using a 24-hour clock (military time). For example, if the first patient arrived at 8:00 AM record 08:00. If the first patient arrived at 1:00 PM, record 13:00.

Module 6:

Data Analysis and Presentation of Results

Overview

This section provides guidance for presenting the results from the QIQ. The plan of analysis is directly linked to the short list of 25 indicators and is designed as a guide to report results to various audiences. The suggested tables highlight results that are important to program managers, policy makers, and researchers alike. The analysis should not be limited to these tables; rather, they should serve as a foundation and be tailored to the interests of the intended audience. These results may be more effectively communicated to a policy audience when presented in graphic format, as shown in the section "Graphic presentation of short list results." Users are encouraged to incorporate other presentation formats (e.g., bar charts, pie charts, etc.) that may better illustrate the results. Both the tabular and graphic summary results that follow use the Ecuador QIQ as an example.

Note: The instruments contain all of the indicators on the short list. The specific variables used to measure each of the 25 short list indicators appear in Appendix A, unless otherwise indicated in the section that follows (in some instances additional calculations are required). Also, other variables that were deemed important by professionals in this field were included on the instruments during the field test and have been retained for future use. A list of these additional indicators appears in Appendix B.

Summary Results from the Short List of Indicators

The tables below illustrate the presentation of tabular results using the Ecuador data as an example. The results are directly linked to the 25 short list indicators and are organized under the following sub-headings: provider counseling and communication, provider follows infection control procedures, provider recognizes/identifies contraindications, provider performs clinical procedures according to guidelines, staff treatment of client, method selection and confidentiality, and facility readiness.

Table 1. Provider counseling and communication skills[20]

	OBS	EXIT
All clients		
I-1: Demonstrates good counseling skills	---	--
I-2: Assures client of confidentiality	---	---
	(n=583)	(n=583)
I-3: Asks client about reproductive intentions: more children?	36.5	52.0
I-3: Asks client about reproductive intentions: when?	27.3	---
I-5: Mentions HIV/AIDS: discussed?	13.4	27.3
New clients (excludes condom users)	(n=131)	(n=131)
I-5: Mentions HIV/AIDS: method protection?	19.2	33.9
I-6: Discusses dual method use	19.1	36.6
All clients	(n=583)	(n=583)
I-7: Treats client with dignity/respect	99.7	100.0
I-8: Tailors key information to the particular needs of the specific client	---	81.6
I-10: Gives instruction on when to return	94.2	96.2
New clients only	(n=145)	(n=145)
I-9: Gives accurate information on the method accepted		
– Explains how to use selected method	83.1	97.2
– Explains side effects of method selected	71.0	80.0
– Explains what to do in case of problems	---	73.1

Questions addressed by Table 1 include:

- What information is exchanged between clients and providers?
- Are new clients given sufficient information to select a method?
- Are new clients given information on possible side effects that could influence method use continuation?

[20] Many programs use a model framework to describe good client-provider interaction. These models are used to train counselors, facilitate supervision, and to provide a mnemonic job aid for counselors. One widely used model is GATHER (**G**reet clients, **A**sk clients about themselves, **T**ell clients about FP methods, **H**elp clients choose a method, **E**xplain how to use method chosen, **R**efer or return for follow-up. Although the QIQ does not include an indicator to determine if GATHER was used in the observed counseling session, one can be created by aggregating indicators that measure the elements of GATHER.

- Are new clients warned about the risk of STIs/AIDS?[21]

High quality client-provider interactions require that certain essential information be exchanged. The topics in Table 1 are essential to the assessment of client needs, identification of appropriate methods, and identification of ancillary risks. The indicators contained in this table help to measure whether the client has made an informed choice and assesses a provider's role in creating high quality client-provider interactions during counseling sessions.

Table 2. Provider follows infection control procedures (I-11)

	Percent
Injectables	(n=46)
– Washes hands before injections	71.7
– Uses newly reprocessed needle and syringe (if reuseable)	93.5
– Cleans and air dries injection site before injection	97.8
Pelvic exams	(n=420)
– Washes hands before exam	58.1
– Uses sterilized or high-level disinfected instruments for each exam	98.3
– Puts on new or disinfected gloves before exam	90.5
– Ensures the instruments and reusable gloves are decontaminated	99.5
IUD insertions	(n=60)
– Uses sterilized or high-level disinfected instruments	100.0
– Washes hands before putting on gloves	66.7
– Gloves hands	100.0
– Washes hands after removing gloves	81.7
– Wipes contaminated surfaces with disinfectant	85.0
– Ensures that instruments and reusable gloves are decontaminated	98.3

Questions answered by Table 2:

- Are providers following infection control procedures as outlined in the guidelines?
- What are areas for improvement with regard to infection control procedures?

This table provides information about provider behaviors that are essential to provide clinical services and maintain aseptic conditions. While this is not a comprehensive list of all behaviors necessary for infection prevention, the selected procedures are those that are fundamental to high-quality services. The above table can be used to help identify if any procedures are not followed as directed by clinical guidelines and to help determine the source of the problem. For example, if sterilized equipment is not used, it could be related to a lack of logistical support for essential equipment or supplies.

[21] Items regarding HIV/AIDS may be less applicable in countries where high-risk behaviors and incidence of HIV/AIDS is relatively low.

Table 3. Provider recognizes/identifies contraindications[22]

Method	*Percent*
Pill (n=30)	6.7
IUD (n=63)	61.9
Injectable (n=46)	80.5
Implant (n=1)	100.0
Female Sterilization (n=2)	50.0
Vasectomy (n=0)*	0.0
Condom (n=18)	0.0
Spermicide (n=10)	50.0
Rhythm/periodic abstinence (n=1)	100.0

*Vasectomies were not included in original data collection from Ecuador but are included here as a placeholder for example.

Questions addressed by Table 3 include:

- How well are clients screened by a program or component of a program?
- Are there methods that are especially prone to ineffective screening or contraindication identification during the client-provider interaction?

Certain provider practices must take place to help the client select the most appropriate contraceptive method for him/her. These practices are often associated with the identification of contraindications for a specific method. A table in the observation guide allows observers to identify and record these provider practices. Each method has a different number of essential practices that the provider must perform to have confidence that he or she is providing the appropriate method. The pill has the most with four different practices to prescribe the method. The results in Table 3 show the percentage of providers that have performed all of the necessary actions required for a given method.

[22] Note: To complete the table, first "select" for the contraceptive method of interest from the "method selection matrix" on the observation guide, and then run a count on the variables listed for that method. For example, for the IUD count "yes" for "check bp (v31A)" and for "ask about last delivery date (v31H)." The table can be completed by recoding the indices created into a "yes/no" variable and running frequencies on the dichotomous variable created.

Table 4. Provider performs clinical procedures according to guidelines (I-13)

	Percent
Injectables	
For new clients	(n= 25)
– Reconfirms client's method choice	100.0
– Ensures client is not pregnant	100.0
For continuing clients	(n= 20)
– Gives injection at correct time	97.8
For all clients (new and continuing)	(n=46)
– Stir/mixes bottle before drawing dose	97.8
– Injects in upper-outer quadrant (if gluteal)	100.0
– Draws back on plunger before injection	97.8
– Allows dose to self-disperse instead of massaging	95.7
– Disposes of sharps in puncture resistant containers	100.0
Pelvic exam	
For all clients (new and continuing)	(n=420)
– Prepares all instruments before exam	98.6
– Inspects the external genitalia	93.1
– Asks the client to take slow deep breathes and relax all muscles	76.2
– Explains speculum procedures to client (if used)	71.8
– Inspects the cervix and vaginal mucosa	96.7
– Performs bi-manual exam gently and without discomfort	89.3
IUD insertion	
For new clients	(n=58)
– Reconfirms method choice	94.8
For all clients (new and continuing)	(n=60)
– Conducts speculum exam to check for RTIs/STIs	86.7
– Conducts bi-manual pelvic exam	93.3
– Visualizes cervix during cleaning	98.3
– Uses tenaculum	100.0
– Sounds the uterus before IUD insertion	100.0
– Uses the no touch technique for inserting the IUD	93.3
– Asks client to wait 15 minutes after insertion	78.3

Questions addressed by Table 4 include:

- Are providers in compliance with recommended clinical procedures for the provision of injectables, pelvic exams, and IUD insertion?
- In which areas are providers strong and/or weak with regard to adherence to clinical procedures?

Table 4 provides information regarding necessary provider actions for three methods: provision of injectables, pelvic exams, and IUD insertion. Low scores suggest a need for re-training, improved clinical practice guidelines, and increased supervision. The above indicators represent a much larger number of behaviors. Consequently, a poor performance in one suggests larger problems with quality. For example, a failure to reconfirm the client's method choice suggests a lack of client-focus in service delivery.

Table 6. Staff treatment of client

	Percent
Staff treatment	(n=584)
I-14 Staff treats client with dignity and respect	99.5

Questions addressed by Table 6 include:

- How do clients feel about the services that they have just received?
- Do clients feel that they were treated well?

This table presents a measure used to assess the client's perceptions and/or emotional response to service delivery provided by the staff. Although a high percentage on this indicator may be indicative of high quality services, it is important to remember that these responses are subjective and can reflect a courtesy bias. Consequently, it is important to interpret this indicator with caution.

Table 7. Method selection and confidentiality

Indicator	OBS	EXIT
All clients		(n=584)
I-17: Client believes the provider will keep his/her information confidential	---	91.2
I-15: Client participates actively in discussion and selection of method (is "empowered")	---	96.6
New clients with a method preference	(n=109)	(n=109)
I-4: Provider discusses with client which method s/he would prefer	99.2	98.1
I-16: Client receives method of choice	79.5	83.5

Questions addressed in Table 7 include:

- Do clients feel that the provider will keep their information confidential?
- Do clients actively participate in the discussion?
- Are contraceptive method preferences discussed with the provider and do clients receive their method of choice?

Table 7 presents a set of measures used to assess the client's treatment during his/her visit. It also addresses an important component of quality of care: method choice. Programs where a high percent of providers discuss the client's preferred method signify that providers are creating an opportunity for clients to express a desire, and, consequently, clients may be more likely to receive their preferred method.

Table 8. Facility readiness

	Percent
	(n=43)
I-18: Has all approve methods; no stockouts[27]	90.7
I-19: Has basic items needed for delivery of methods available through SDP[28]	0.0
I-20: Offers privacy for pelvic exam/IUD insertion	100.0
I-21: Has mechanisms to make programmatic changes based on client feedback	97.7
I-22: Has received a supervisory visit in the past six months	39.5
I-23: Adequate storage of contraceptives and medicines (away from water, heat, direct sunlight) is on premise[29]	100.0
I-24: Has state-of-the-art clinical guidelines	95.3
I-25: Waiting time acceptable (less than 30 minutes)	42.1

Questions addressed in Table 8 include:

- Does the facility have adequate supplies and equipment to deliver the contraceptives methods offered?
- Is the program prepared to respond to client needs (privacy, acceptable waiting time, etc.)?
- Does the facility systematically ensure quality of care through state-of-the-art guidelines and regularly scheduled supervisory visits?

Indicators of "facility readiness" are used to determine the basic capacity of the facility to provide reproductive health services. Information collected about a particular facility's capability to provide services has implications for the ability of the health system as a whole to provide quality services. Staff, supplies, operating procedures, and physical infrastructure may be used to assess facility level functions, while supervision, logistics in staffing and referrals may be used to assess communication with the larger health delivery system.

[23] This proportion is obtained by running a count on ***v2*** and ***v4*** of the facility audit. Next, recode this "count" variable into a "yes/no" variable. The "yes" category is comprised of those that have all of the methods available. The "no" category is comprised of those with a stockout of one or more methods.

[24] This proportion is derived by running a count on v6 on the facility audit. Since the required equipment varies by method, run a count on the essential equipment by method (see Appendix C for list of essential equipment by method). Next, recode the "count" variables for each method supplied at the facility into a "yes/no" variable. The "yes" category is comprised of those that have all of the essential equipment for a given method. The "no" category represents those that have one or more pieces of essential equipment missing. To obtain the summary score reported above, run a count to determine if the facility has the essential equipment for all of the methods. Recode this count variable into a "yes/no" variable as above.

[25] To obtain this proportion, run a count on ***v7a*** and ***v7b***. Recode this count variable into a "yes/no" variable. The "yes" category is comprised of those that are **both** protected from rain and off the floor and on shelves.

Monitoring Trends Over Time

A major goal of most programs is to improve services over time. Ideally, measures taken **after** an intervention is put in place should demonstrate that there has been improvement in services over time (time 1 versus time 2). While it is possible to simply look at the numbers at two (or more) different points in time to determine if there is improvement, it is not sufficient to just do this "eyeball" test. Since there is some error associated with all measures, a given estimate is not likely to represent the actual value of the parameter of interest. The extent to which an estimated value differs on average from the true value of the parameter being measured is the **accuracy** of a measure, which is dependent on its **reliability** and **validity**. **Reliability** (or variance) is how reproducible the estimated value is over repeated trials, and **validity** (or bias) is the extent to which an estimated value (over repeated trials) differs from the "true" value of the parameter being estimated (Levy and Lemeshow, 1991).

Reliability and validity are two error components that affect the accuracy of an estimated value. Reliability (or variance) can be controlled by larger sample sizes or through the choice of sampling design. Larger sample sizes tend to have less variability, as do simple random sample or systematic sample designs (in comparison to multi-stage cluster sampling), thus yielding more reliable results. Validity (or bias) can be controlled through the study design and the measurement process.

It is important to exercise caution when interpreting results because they are **estimates** of the true values. Small changes between two times may be due to random error rather than actual changes. At a single point in time we can put a confidence interval around the proportions to indicate the range in which the true value is likely to lie.

Suppose the number of responses at the individual level is approximately 600. For these estimates, we can be 95% confident that the true value lies within 5 percentage points of these estimates. For example, if 50% of those sampled report that the "provider treated him/her with respect/courtesy," we are 95% confident that the true value lies between 45% and 55%.

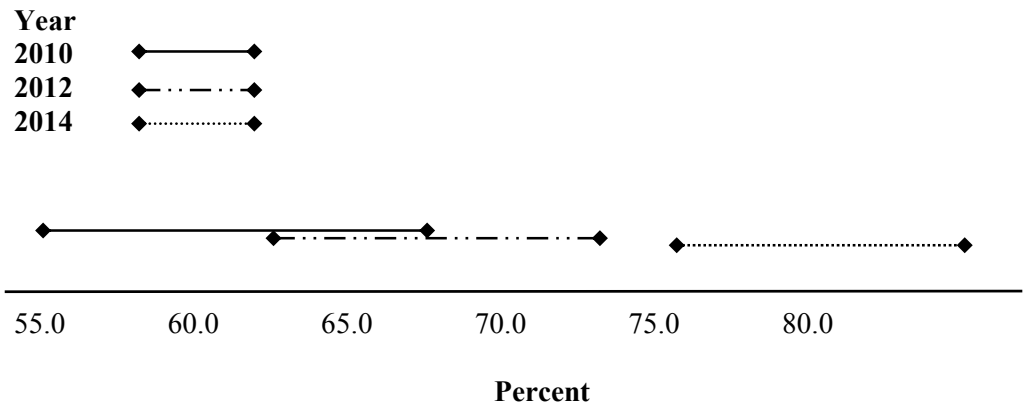
If the sample size at the facility level is 40, we can be 95% confident that the true value is within 15 points of the estimate. If fifty percent of the facilities report that they have all methods available, we can be 95% confident that the true value is between 35% and 65%. If there are 100 facilities in the sample, we are 95% confident that the true value lies within ten percentage points. If the estimate is 50%, we can be 95% confident that the true value lies between 40 and 60 percent.

If we have data from more than one time, we can do statistical analyses to determine if there is change over time. The example below illustrates why it is important to use statistical tests, rather than simply looking in the percent changes at two different times.

Illustrative Example 1.

Indicator I-18: Facility has all (approved) methods; no stockouts

Year	2010	2012	2014
Percent "yes" (n=400)	60.0	65.0	75.0
95% Confidence Interval	55.2, 64.8	60.4, 69.6	70.8, 79.2



Suppose we are interested in determining the extent to which Ministry of Health (MOH) facilities in country X have all approved methods available (no stockouts). In 2010, a program is implemented to improve the delivery of contraceptive methods to facilities in the MOH system. The percent of facilities that have all approved methods is then measured in the years 2010, 2012, and 2014. We would like to determine if there has been a "real" improvement in this indicator over time.

In the above example, 400 facilities are sampled at three different points in time. For each year, the percent of facilities that have all approved methods is given along with the 95% confidence interval. For 2010 we are 95% confident that the true value is between 55.2 and 64.8 percent. In 2012 we are 95% confident that the true value is between 60.4 and 69.6, and in 2014 we are 95% confident that the true value is between 70.8 and 79.2. The above diagram illustrates that the confidence intervals about the scores for 2010 and 2012 overlap. Since we do not know where the true value lies within the confidence interval, we cannot conclude that there was a difference in the percent of facilities with all methods between the two years. When we look at the possible range of values between 2012 and 2014, we see that the confidence intervals do not overlap. Since they do not overlap, we can conclude that there was an improvement in the percent of facilities that had all methods available between the years 2012 and 2014.

Statistical tests must be used in order to determine if there has been "real" change over time. In order to determine if the difference from time 1 to time 2 is significant (in statistical terms), or if it is so small that it could have happened by chance, it is necessary to run a statistical test. While from the above examples it may appear that there is an improvement over time, in order to definitively reach

this conclusion it is important to determine if there is a statistical significance between the estimates at time 1 versus time 2.

In order to determine if the observed difference can be considered significant, a statistical method called the Chi square test for independence may be used. The results from the Chi square are interpreted by looking at the p-value from statistical programs (e.g., STATA, SPSS, Epi-Info, SAS). If the p-value is less than .05 you can conclude that the difference between time 1 and time 2 is significant. A p-value of less than .05 indicates that there is less than a five percent chance that the observed change is due to chance alone. If the value is greater than .05, the difference between time 1 and time 2 it is not considered significant because there is a greater than five percent chance that the observed change was due to chance alone, and one cannot conclude that the program has improved over time.

Below is an illustrative example of how to determine if the program has improved over time using the Chi-Square test of independence.

Illustrative Example 2.

Facility has all (approved) methods	Time 1 (2012)	Time 2 (2014)
	n=500	n=500
Yes	80% (400)	85% (425)
No	20% (100)	15% (75)
Total	100% (500)	100% (500)

Chi square= 4.33
p-value= .038

In this example, the p-value is below .05 so there is a significant difference between the two times with regard to methods available at the facility. There are significantly more methods available in 2014 (85%) than in 2012 (80%).

Graphic Presentation of Shortlist Results

Figure 1.
Provider Demonstrates Good Counseling Skills (I-1)

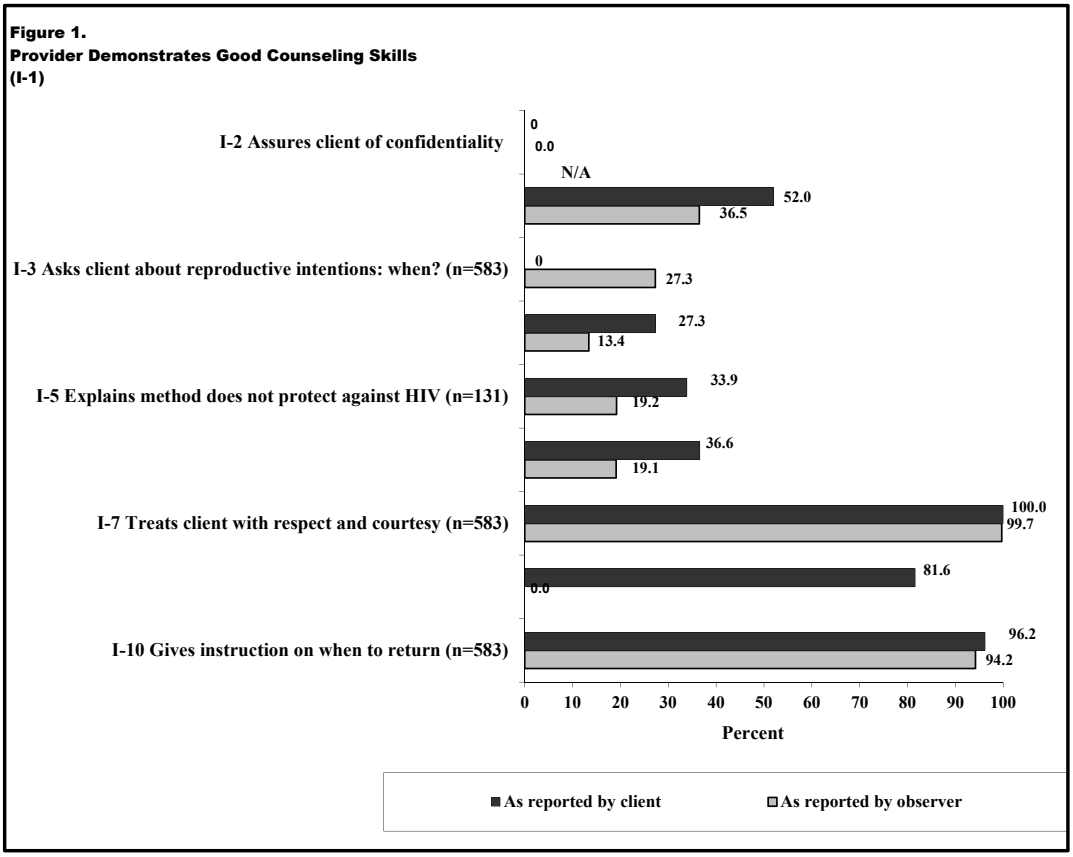


Figure 2.
Provider Gives/ Client Receives Accurate Information on Method Accepted (I-9)

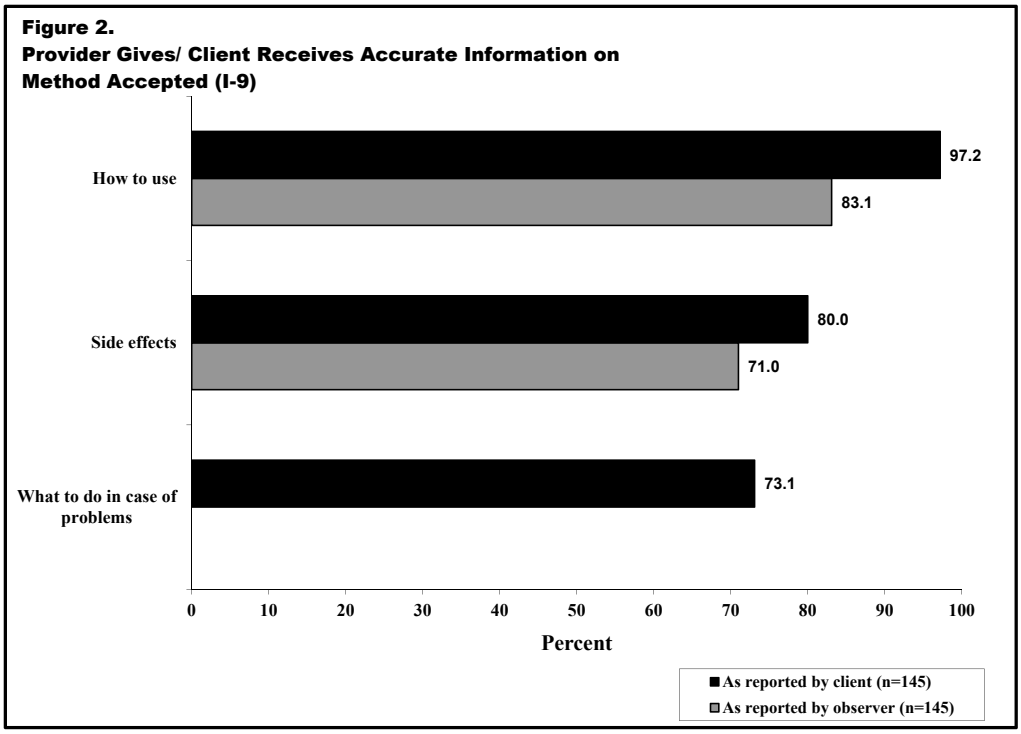
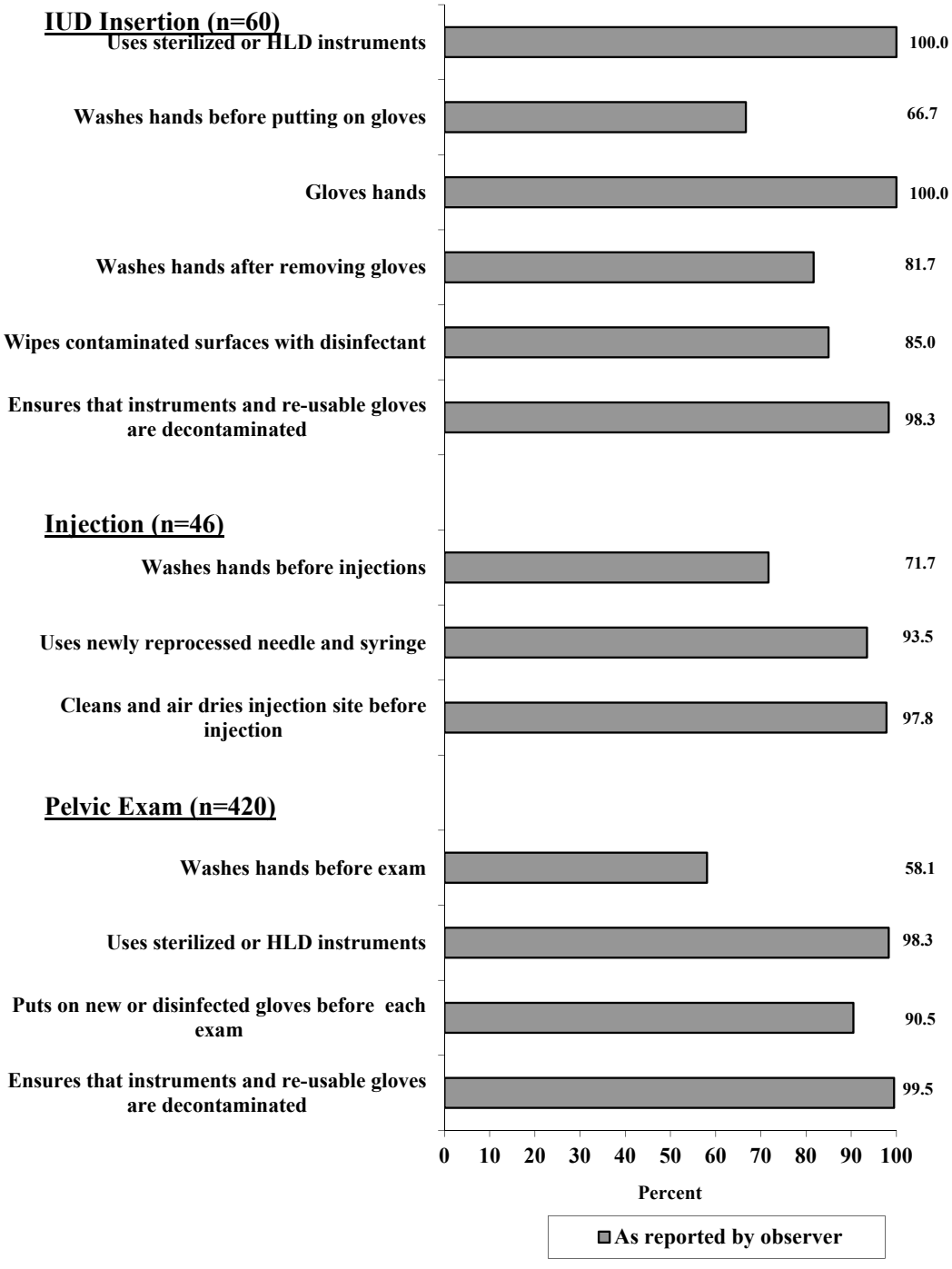


Figure 3.
Provider Follows Infection Control Procedures (I-11)



* Vasectomies were not included in original data collection from Ecuador but are included here as a placeholder for example.

Figure 4.
Provider Recognizes Contraindications Consistent with Guidelines (among new clients) (I-12)

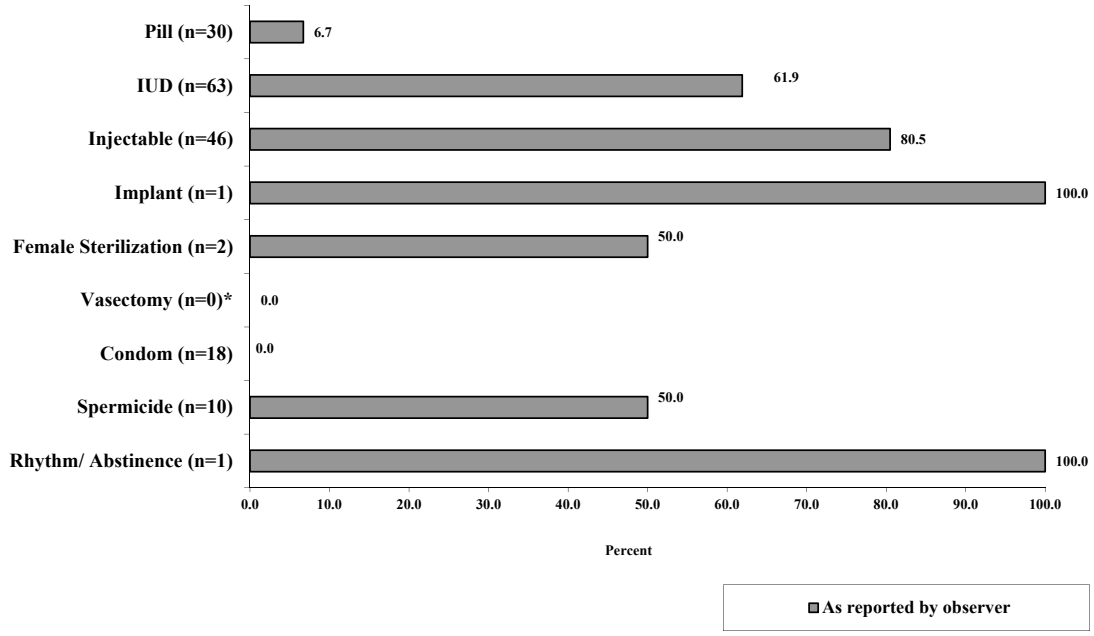


Figure 5.
Provider Performs Procedures According to Guidelines
(I-13)

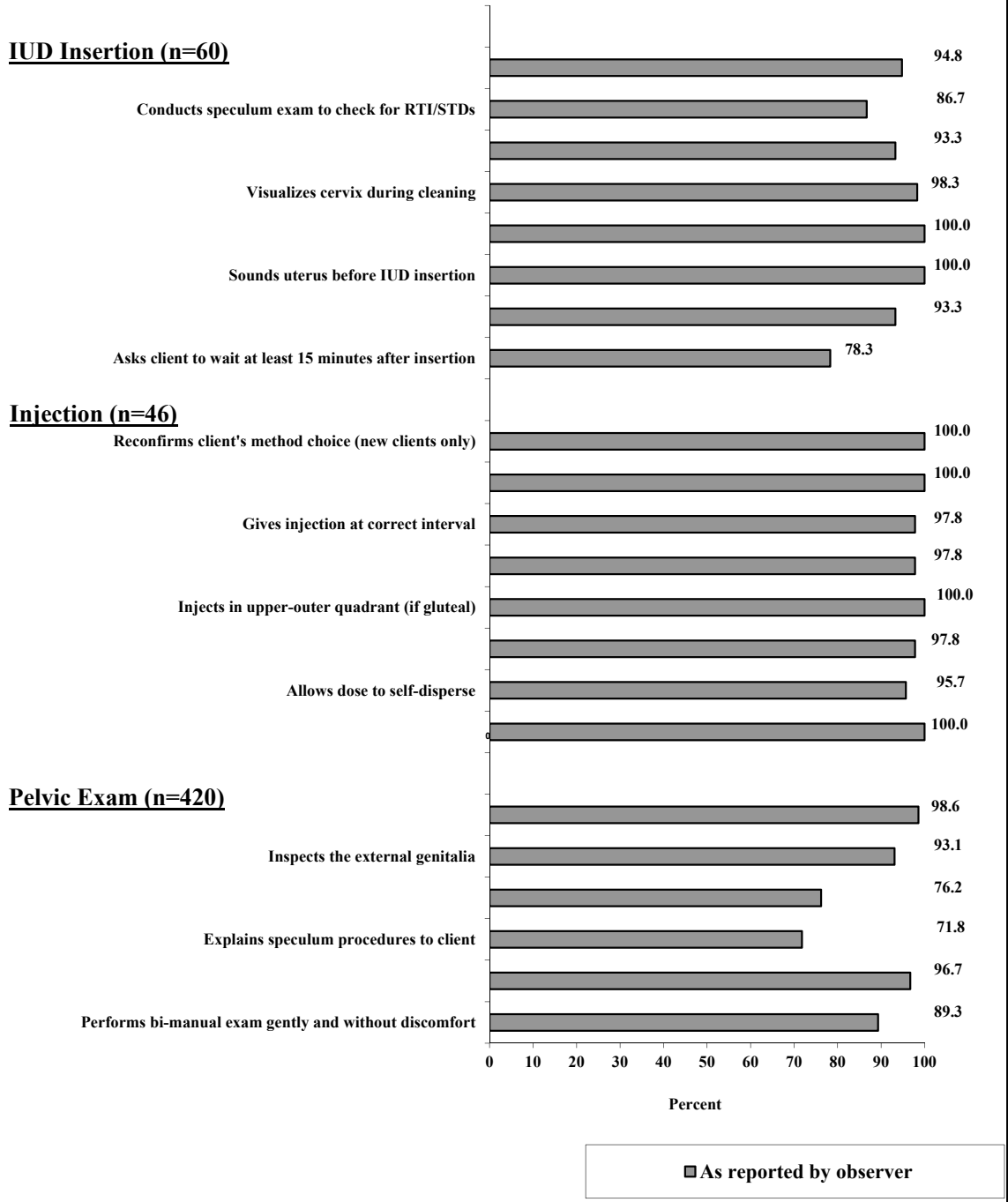
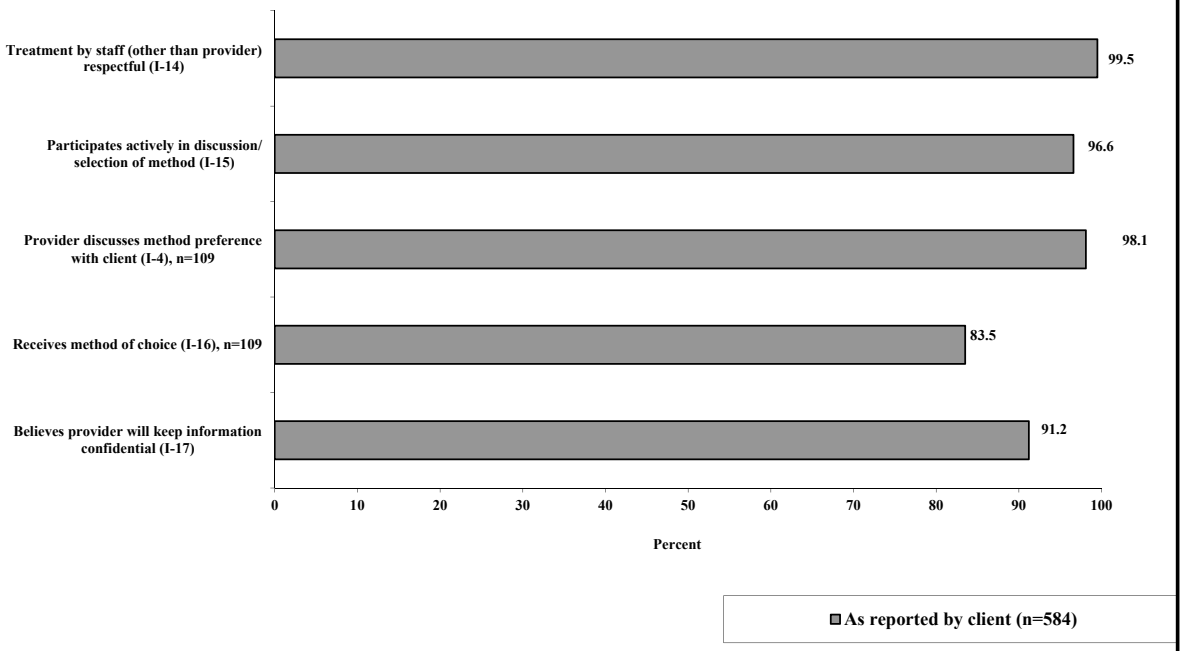


Figure 6.
Clients' Perceptions of Services Received- Other Dimensions



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Appendix A: Short List of Indicators Matched with Corresponding Items on QIQ Instruments

Indicator Number	INDICATOR	EXIT INTERVIEW	OBSERVATION	FACILITY AUDIT
	PROVIDER			
I-1	Demonstrates good counseling skills		**Provider Action Index** **V23.** Did the provider: A. Ask open ended questions B. Encourage client to ask questions C. Treat client with respect D. See client in private E. Discuss return visit F. Ask client his/her concerns with method H. Use a client record I. Assure client of confidentiality	
I-2	• Assures client of confidentiality		**V23.** Did the provider: I. Assure client of confidentiality	
I-3	• Asks client about reproductive intentions (more children? When?)	**V134.** Did you and the provider talk about whether or not you would like children in the future?	**V24.** Information provided: **D.** Desire to have more children **E.** Timing of next child	
I-4	• Discusses with client which method s/he would prefer	**V109.** Which method did you want when you came here? **V110.** Which methods did the provider discuss with you?	**V27.** Client stated preference for method	

Indicator Number	INDICATOR	EXIT INTERVIEW	OBSERVATION	FACILITY AUDIT
I-5	• Mentions HIV/AIDS (initiates or responds)	**V129.** During your talk with the provider was STIs/AIDS discussed? **V116.** For the method you decided to accept, did the provider: D. Explain that this method does not provide protection against STIs and AIDS?	**V24.** Information provided: I. HIV/AIDS and STIs discussed **V33.** Did the provider: A. Explain method does not provide protection against STIs and AIDS	
I-6	• Discusses dual method use	**V130.** Did the provider encourage you to use condoms at the same time as the family planning method you chose or are currently using?	**V33.** Did the provider: B. Encourage use of condoms as a second method?	
I-7	• Treats client with respect /courtesy	**V125.** During your visit to the clinic how were you treated by the provider?	**V23.** Did the provider: C. Treat client with respect?	
I-8	• Tailors key information to the particular needs of the specific client	**V120.** Do you feel the information given to you during your visit today was too little, too much, or just about right?		
I-9	• Gives accurate information on the method accepted (how to use, side effects, complications)	**V116.** For the method you decided to accept, did the provider: **A.** Explain to you how to use the method effectively? **B.** Describe possible side effects? **C.** Tell you what to do if you have any problems?	**V32.** Provider gave accurate information on key point: **A.** How to use **B.** Side effects	
I-10	• Gives instructions on when to return	**V118.** Were you told when to return for a follow-up visit?	**V23.** Did the provider: E. Discuss return visit?	

Indicator Number	INDICATOR	EXIT INTERVIEW	OBSERVATION	FACILITY AUDIT
I-11	Follows infection control procedures outlined in guidelines		Injectables: **D-4.** Wash hands before injections **D-5.** (If reusable) use newly reprocessed needle and syringe **D-7.** Clean and air-dry injection site before injection Pelvic Exams: **P-3.** Wash hands before exam **P-4.** Use sterilized or HLD instruments for each exam **P-5.** Put on new or disinfected gloves before each exam **P-11.** Ensure that instruments and re-usable gloves are decontaminated IUD: **I-3.** Use sterilized or HLD instruments **I-4.** Wash hands before putting on gloves **I-5.** Glove hands **I-12.** Wash hands after removing gloves **I-14.** Wipe contaminated surfaces with disinfectant **I-15.** Ensure that instruments and re-usable gloves are decontaminated	
I-12	Recognizes/ identifies contraindications consistent with guidelines		**V31.** Method selection matrix	

Indicator Number	INDICATOR	EXIT INTERVIEW	OBSERVATION	FACILITY AUDIT
I-13	Performs clinical procedures according to guidelines		Injectable **D-1.** Reconfirm new client's method choice **D-2.** Ensure new client is not pregnant **D-3.** Give injection at correct time **D-6.** Stir/mix bottle before drawing dose **D-8.** (If gluteal) inject in upper outer quadrant **D-9.** Draw back on plunger before injection **D-10.** Allow dose to self-disperse instead of massaging **D-11.** Dispose of sharps in puncture resistant container Pelvic exam **P-2.** Prepare all instruments before exam **P-6.** Inspect external genitalia **P-7.** Ask client to take slow, deep breaths, and relax all muscles **P-8.** (If used) explain speculum insertion procedure to client **P-9.** Inspect cervix and vaginal mucosa **P-10.** Perform bimanual exam gently and without discomfort to client	

Indicator Number	INDICATOR	EXIT INTERVIEW	OBSERVATION	FACILITY AUDIT
I-13	Performs clinical procedures according to guidelines (Cont.)		IUD **I-2.** Reconfirm new client's method choice **I-6.** Conduct speculum exam to check for RTI/STIs **I-7.** Conduct bimanual pelvic exam **I-8.** Visualize cervix during cleaning **I-9.** Use tenaculum **I-10.** Sound uterus before IUD insertion **I-11.** Use the no-touch technique for inserting the IUD **I-13.** Ask client to wait/rest for at least 15 minutes after insertion	
	STAFF (other than provider)			
I-14	Treat clients with dignity and respect	**V126.** During your visit to the clinic how were you treated by the other staff?		
	CLIENT			

Indicator Number	INDICATOR	EXIT INTERVIEW	OBSERVATION	FACILITY AUDIT
I-15	Participates actively in discussion and selection of method (is "empowered")	**V119.** Did you feel comfortable to ask questions during the session?	**V24.** Information Client Provided[30]: **A.** Current age **B.** Marital/relationship status **C.** Number of living children **D.** Desire for more children **E.** Timing of next child **F.** Current pregnancy status **G.** History of pregnancy complications **H.** Partner's attitude about FP **I.** Multiple/single sexual partner (s) **J.** Partner multiple/single sexual partner (s) **K.** HIV/AIDS discussed	
I-16	Receives his/her method of choice	**114.** (To be answered by interviewer) Did the client receive his/her method of choice? (Check questions #109 and #113) Is the method named in #109 and #113 the same? **Related explanatory variables:** **V115.** Why do you think you did not get (preferred method)?	**V28.** Preferred method received? **Related explanatory variables:** **V30.** Reason preferred method not received: **V26.** Method actually received/prescribed.	

Indicator Number	INDICATOR	EXIT INTERVIEW	OBSERVATION	FACILITY AUDIT
I-17	Client believes provider will keep his/her information confidential	**V126.** Do you believe that the information that you shared about yourself with the provider will be kept confidential?		
	FACILITY			
I-18	Has all (approved) methods available; no stockouts			**V2.** Which contraceptive methods are provided at this facility? Record which contraceptive methods are usually provided at this facility. If it is available at the facility today, count the approximate number of non-expired units of each method available in either the facility or the storeroom. For each method provided, ask whether there has been a stockout in the last six months. **V4.** Which services are offered at this facility? For each service, first record if it is provided, and then record whether the service has been available at <u>all</u> times in the last six months. If the service has NOT been available at all times in the last six months, mark the reason why it was <u>last</u> not available.

Indicator Number	INDICATOR	EXIT INTERVIEW	OBSERVATION	FACILITY AUDIT
I-19	Has basic items needed for delivery of methods available through SDP (sterilizing equipment, gloves, blood pressure cuff, specula, adequate lighting, water)			**V6.** Which of the following types of equipment are available and in working order? Ask to see each type of equipment. If there is at least one available in working order, mark the corresponding box on the table. **V10a.** What is the source of water used at the facility today?
I-20	Offers privacy for pelvic exam/IUD insertion (no one can see)	**V121.** Did you have a pelvic exam during your visit today (*filter*)? **V122.** Did you have enough privacy during your exam? (PROBE: Could clients or staff other than those caring for you see you?)	**P-1.** Ensure client privacy (pelvic exam) **I-1.** Ensure client privacy (IUD insertion)	**V9.** Ask the respondent, "May I see where family planning clients are examined?" Choose the response that best describes where the examinations take place.
I-21	Has mechanisms to make programmatic changes based on client feedback			**V16.** What methods do you have for determining client opinions? **V17.** In the past quarter (3 months) have any changes been made in the program based on feedback from clients? **V18.** What changes have taken place? **V19.** What methods do you have for determining provider opinions? **V20.** In the past quarter (3 months), have any changes been made as a result of provider opinions? **V21.** What changes have taken place?

Indicator Number	INDICATOR	EXIT INTERVIEW	OBSERVATION	FACILITY AUDIT
I-22	Has received a supervisory visit in past __ months			**V13.** What was the date of the last "outside" supervisory visit which included a review of family planning services?
I-23	Adequate storage of contraceptives and medicines (away from water, heat, direct sunlight) is on premises			**V7.** Are facilities for storing contraceptives adequate in the following respect: **A.** Products are protected from the rain. **B.** Products are off the floor and on shelves.
I-24	Has state-of-the-art clinical guidelines			**V14.** Please show me the most recent version of written guidelines and protocols for delivering family planning services.
I-25	Waiting time acceptable	**V127.** How long did you wait between the time you first arrived at this clinic and the time you saw a staff person for a family planning consultation? **Related Explanatory Variable:** **V128.** Do you feel that your waiting time was reasonable or too long?		**V1c.** What time (at or after the clinic opened) did the first client arrive? **V1d.** What time was the first client seen? **Related Explanatory Variables:** **V1a.** What time is the clinic scheduled to open? **V1b.** What time did the clinic actually open?

Appendix B: Summary Table: Items on QIQ Instruments Not Associated with Short List Indicators[26]

TOPIC	EXIT INTERVIEW	OBSERVATION	FACILITY AUDIT
Facility Characteristics	**V01.** Health Facility (Name & Number) **V02.** District (Name & Number) **V03.** Region (Name & Number) **V04.** Date of Interview **V05.** Type of Facility **V06.** Type of Sector **V07.** Locality of Facility	**V01.** Health Facility (Name & Number) **V02.** District (Name & Number) **V03.** Region (Name & Number) **V05.** Date of Observation **V07.** Type of Facility **V08.** Type of Sector **V09.** Locality of Facility	**V01.** Health Facility (Name & Number) **V02.** District (Name & Number) **V03.** Region (Name & Number) **V04.** Date of Interview **V05.** Type of Facility **V06.** Type of Sector **V07.** Locality of Facility **V8.** Verify that there is a waiting area with seating that is sheltered from sun and rain at the clinic. **V11.** Is there a sign on the street or on the exterior of the building announcing that family planning services are available? **V15.** Show me where all of the client records are kept.
Provider Characteristics		**V11.** Provider providing MOST of the counseling session **V12.** Sex of the provider **V41.** Provider performing MOST of the clinical examination **V42.** Sex of provider	

TOPIC	EXIT INTERVIEW	OBSERVATION	FACILITY AUDIT
Client Characteristics	**V137.** How old were you at your last birthday? **V136.** Have you ever attended school? **V137.** What is the highest level of school that you attended? (Probe: Did you attend primary, secondary, or higher?) **V138.** What is the highest grade/form/year that you attended at that level?	**V13.** Sex of Client **V24.** Information provided: A. Current age	
	V139. Before we finish, I'd like to ask you some questions about yourself and your household. Could you describe the main material of the floor of your home? **V140.** What is your main source of drinking water? **141.** Do you have or does anyone in you house have . . .? **142.** Does your household have . . .? **143.** What is the main language that you speak at home? **V144.** What is your ethnicity? **V145.** What is your religion? **V146.** What is your current marital status? **V147.** Sex of Client	**V21.** Language spoken	
Client FP Background	**V100.** Have you ever visited this site for family planning services before today? **V101.** What was the reason for your visit today? **V102.** What contraceptive method are you/were you last using (in the past 6 months)? **V108.** Did you come here today to obtain a specific contraceptive method?	**V22.** Previous contact with provider **V 25.** Outcome of visit **V20.** Family planning status upon arrival at this facility	

[26] This list is comprised of items of importance, which are in addition to short list of indicators.

TOPIC	EXIT INTERVIEW	OBSERVATION	FACILITY AUDIT
Method Problems	**V103.** Did the provider ask if you were having a problem with the method (Probe: or did you mention a problem)? **V104.** Have you had a problem with your method (Probe: that you wanted to discuss with your provider)? **V105.** Did the provider try to understand the nature of your problem? **V106.** Did the provider suggest what you should do (action you should take) to resolve the problem? **V107.** Were you satisfied with the advice or treatment that you received for your problem?		
Method Selection	**V111.** Did you receive a contraceptive method today? **V112.** Were you given a prescription or a referral for a method today?	**V29.** Provider determined client reason for method selection?	
Reproductive Intentions	**V131.** How many children of your own do you have? **V132.** Would you like to have (a/another) child in the future? **V133.** How long would you like to wait from now before the birth of (a/another) child?		
Accurate Knowledge	**V117.** Circle the method received, prescribed, or referred for and ask the questions that correspond to the method: **A. Pill:** How often do you take the pill? **B. IUD**: What should you do to make sure that your IUD is in place? **C. Injectable:** How long does the Depo Provera injection provide protection against pregnancy?		

TOPIC	EXIT INTERVIEW	OBSERVATION	FACILITY AUDIT
	D. **Implant:** How long does an implant provide protection against pregnancy? **E. Female Sterilization:** Once you have been sterilized, could you ever become pregnant again? F. **Vasectomy:** Once you have been sterilized, can you ever impregnate a woman again? **G. Condom:** How many times can you use a condom? H. **Spermicide:** Approximately how long before intercourse should you insert the vaginal tablet? I. **Periodic abstinence/rhythm:** How do you recognize the days on which you should not have sexual intercourse? J. **LAM:** Can you use this method if your menstrual period has returned? K. **Diaphragm:** Approximately how long after intercourse should the diaphragm remain in place?		
Privacy	**V123.** When meeting with the provider during your visit do you think other clients could hear what you said? This does not include the outside observer.		
IEC Materials		**V23.** Did the provider: G. Use visual aids?	**V12.** Which family planning IEC materials are available?

TOPIC	EXIT INTERVIEW	OBSERVATION	FACILITY AUDIT
Service Statistics			**V22.** How many clients received family planning services in the last 4 completed quarters (total new FP acceptors and total FP visits)? **V23.** Overall, how many client visits for MCH, FP, general exams, etc. were recorded at this clinic in the last 4 complete quarters? **V24.** On an average day, how many providers are available to see family planning clients?
Other		**V04.** Provider name and ID Number **V06.** Observer name and ID Number **V10.** Time observation session began and ended **V40.** Clinical provider same person who provided counseling **V43.** Observation conducted for **A.** Client received injectable **B.** Client underwent pelvic exam **C.** Client had an IUD inserted	

Appendix C: Required Equipment and Supplies for Each Contraceptive Method

The Table below details the equipment that is required for each contraceptive method. An "M" indicates that the piece of equipment or the supply is mandatory to provide this method and a check (√) indicates that the piece of equipment is needed, but is not mandatory. Shaded boxes indicate that the piece of equipment or the supply is not required to provide this method. Equipment must be available **and** functioning. For example, if the flashlight has no batteries in it and the site has no batteries available, it is not functioning. If the tenacula or the sterilizer is broken, it is not functioning. Do not mark that an item is available unless it is available **and** functioning.

Note: Many of the items listed below will be found in "minilap kits," IUD kits," or "no-scalpel vasectomy kits." If the facility has such kits, the individual pieces should be listed for the relevant method. Equipment may be found in the family planning room or procedure area, in the operating theater, or in the recovery room.

EQUIPMENT AND SUPPLIES	Pill	IUD	Injectable	Implant	Vasectomy	Minilap local anesthesia	Minilap general anesthesia	Laparotomy
Flashlight/lamp		✓			✓	✓	✓	✓
Scale	✓						✓	✓
Blood pressure gauge	✓				✓	✓	✓	✓
Thermometer					✓	✓	✓	✓
Stethoscope					✓	✓	✓	✓
Scissors		✓			✓	✓	✓	✓
Sterile needles and syringes			✓	✓	✓	✓	✓	✓
Specula		✓				✓	✓	
Tenacula		✓				✓	✓	
Uterine sound		✓						
Alligator forceps[31]		✓		✓				
Sponge holding forceps		✓				✓	✓	✓
Artery forceps				✓	✓	✓	✓	✓
Dressing forceps						✓	✓	✓
Tissue forceps					✓	✓	✓	✓

[27] Mandatory for removal: If you supply these methods you must be equipped to remove them also.

EQUIPMENT AND SUPPLIES	Pill	IUD	Injectable	Implant	Vasectomy	Minilap local anesthesia	Minilap general anesthesia	Laparotomy
Mosquito forceps				✓	✓	✓	✓	
Intestinal forceps						✓	✓	
Babcock forceps						✓	✓	
NSV ringed forceps					✓			
Scalpels				✓	✓	✓	✓	✓
Sutures					✓	✓	✓	✓
Needle holder					✓	✓	✓	✓
Retractor						✓	✓	
Tubal hook						✓	✓	
Sharp trocars				✓				
Sterilizers		✓	✓[32]	✓	✓	✓	✓	✓
Iodine		✓		✓	✓	✓	✓	✓
Xylocaine or lignocaine				✓	✓	✓	✓	✓
Antiseptic		✓	✓	✓	✓	✓	✓	✓
Decontamination solution		✓	✓	✓	✓	✓	✓	✓
Sterile gloves		✓		✓	✓	✓	✓	✓
Disposal containers for contaminated waste/supplies		✓	✓	✓	✓	✓	✓	✓
Sharps containers for used sharps			✓	✓	✓	✓	✓	✓
Plastic buckets or containers for decontamination		✓	✓	✓	✓	✓	✓	✓
Clean instrument containers				✓				
Instrument trays		✓	✓	✓	✓	✓	✓	✓
Swab containers with sterile swabs or sterile gauze		✓	✓	✓	✓	✓	✓	✓
Examination couch or table		✓		✓	✓	✓	✓	✓
Examination table capable of trendelenburg						✓	✓	✓
Operation theater					✓	✓	✓	✓

[28] Only mandatory if using reusable needles or reusable syringes.

EQUIPMENT AND SUPPLIES	Pill	IUD	Injectable	Implant	Vasectomy	Minilap local anesthesia	Minilap general anesthesia	Laparotomy
Recovery room					✓	✓	✓	✓
Procedure area for IUD, injectables or NORPLANT		✓	✓	✓				
Private counseling area for all methods	✓	✓	✓	✓	✓	✓	✓	✓

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